Utilising a Bourdieusian lens to explore emerging health visitor practice education experiences within the context of the Health Visitor Implementation Plan

Thesis submitted in accordance with the requirements
of the University of Chester for the degree of
Professional Doctorate in Health & Social Care

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Declaration

The material being presented for examination is my own work and has not been submitted for an award of this or another HEI except in minor particulars which are explicitly noted in the body of the thesis. Where research pertaining to the thesis was undertaken collaboratively, the nature and extent of my individual contribution has been made explicit.

Signed Deborah Ann Haydock

Dated 8/11/18

Summary of portfolio

This thesis is set within the context of a Professional Doctorate programme in Health and Social Care, comprising two elements: the successful completion of a taught component and thesis submission. The taught component included the following modules:

Doctoral studies in context
Research methods for professional enquiry
Leadership
Management and organisation
Writing for publication
Social theories
Preparing for thesis.

These modules were the starting point for this thesis and were pivotal in preparation for this study.

Abstract

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Title of study: Utilising a Bourdieusian lens to explore emerging health visitor practice education experiences within the context of the Health Visitor Implementation Plan.

The Health Visitor Implementation Plan (HVIP) (DH, 2011a) changed the recruitment criteria for health visiting and the way health visitor (HV) practice placements were supported. Several universities offered accelerated '2+1' programmes, where a graduate with a health related degree obtained accreditation of prior learning and completed pre-registration nurse training in two rather than three years. This was then followed by a one-year post-registration Health Visitor programme. This widening of recruitment afforded a unique opportunity to explore the experiences of 2+1 HV students, practice teachers (PTs) and mentors, and emerging practice education models within the context of the HVIP. Findings are considered through the lens of Bourdieu's theory of practice.

The study adopted an interpretive phenomenological design to gain a deeper understanding of the experiences of students, PTs and mentors. In-depth semi-structured conversational interviews were undertaken with four HV 2+1 students, two PTs and two mentors. Interviews were recorded, transcribed and analysed using Interpretative Phenomenological Analysis.

Findings viewed through a Bourdieusian lens indicate that policy change in the form of the HVIP affected the structure of the social field, resulting in a period of transition when some participants had difficulty adapting to the changed social context. Long arm models of practice education added to the complexity of the PT role, including the additional responsibility of overseeing numerous students and mentors. Mentors reported feeling under pressure, exacerbated by working in inexperienced teams; and frustration that their contribution to the HVIP was disregarded, compounded by a lack of opportunity for professional progression. Students undertaking different routes into nursing are affected by extrinsic views and this affects evolving habitus and enculturation. When students' prior experience is valued, this strengthens the students' perception of their 'field' position. Placement changes, particularly during consolidation, can be detrimental as they affect habitus formation and student learning and impact upon assessment processes.

The research offers new insights into health visiting practice education and the impact of policy change on practice settings. The findings have implications outside health visiting in the current context of changes to nurse education and the introduction of the new NMC (2018b) standards for student supervision and assessment. New knowledge is offered with regards to the significance of transition periods, changing roles, and the potential impact upon the provision of student practice placements and those who support them. Recommendations are made for further areas of research, practice placement providers and HEIs.

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List of abbreviations

Accreditation of prior learning (APL)

Abbreviation for British exit, refers to Britain withdrawing from the European Union (BREXIT)

Community Nursery Nurse (CNN)

Continuing professional development (CPD)

Department of Health (DH)

Health Education England (HEE)

Health Visitor (HV)

Health Visitor Implementation Plan (HVIP)

Healthy Child Programme (HCP)

Higher Education Institutes (HEIs)

Institute of Health Visiting (iHV)

Local Authority (LA)

Local Education and Training Boards (LETBs)

Long arm mentorship (LAM)

Modernising Nursing Careers (MNC)

National Health Service (NHS)

Nursing and Midwifery Council (NMC)

Practice Teacher (PT)

Public Health (PH)

Public Health England (PHE)

Registered General Nurse (RGN)

Royal College of Midwives (RCM)

Royal College of Nursing (RCN)

Specialist community public health nurses (SCPHN)

Specialist community public health nurses – Health Visitor (SCPHN-HV)

Teaching Excellence Framework (TEF)

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Chapter 1: Introduction and background

The chapter opens with a personal reflection on the doctoral journey, Bourdieusian concepts and the formation of habitus. The historical context of the study is outlined and the thesis organisation and structure is explained. A summary of each chapter's contents is given, leading to an overview of the historical background to the development of the health visiting profession set within the wider context of nurse education. The thesis is located within the current political climate referred to as neoliberalism,[1] and key policy drivers are critically reviewed, including the implications for healthcare provision of neoliberalist policy and fiscal austerity.

Personal reflection

I have chosen to commence this study on a personal note, reflecting upon the origins of this doctoral journey. This research was commenced following a change of career from a role in clinical practice to an academic role in 2012. As a former health visitor with over 27 years' health visiting experience, I teach across a range of programmes including pre-registration Nursing, Specialist Community Public Health Nursing (SCPHN) and a Master's degree in Public Health. As a former practice teacher (PT) for health visitors (HV) for 12 years, I have a particular interest in HV practice education, and within the university I act as practice lead for SCPHN and Specialist Practice Community (SPC) education. This thesis builds upon research I have previously undertaken in the field of SCPHN and SPC practice education and I feel that this is my hinterland, an area lying beyond the visible and the known. The thesis findings are located through the lens of Pierre Bourdieu's theory of practice (Bourdieu, 1977) and his key concepts of habitus, cultural capital and field.[2]

Bourdieu's concept of habitus conceptualises the internalisation of social structures when applied to self; it encompasses cultural, historical and structural aspects, the outer becoming embodied within. Identity formation is a complex process for all individuals and as a researcher I am not immune to this process.

[1] Neoliberalism is a theory of political economic practices that proposes that human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterised by strong private property rights, free markets and free trade. The role of the state is to create and preserve an institutional framework appropriate to such practices (Harvey, 2005, p.2)

[2] Developed in the 1960s, Bourdieu's theory of practice incorporates the key concepts of habitus, cultural capital and field, referring to them as thinking tools. Bourdieu considers practice to result from an individual's habitus, their experience and their position within the field. This position is considered in terms of capital in the game of play.

Having considered my professional background and its implications from a research perspective, I have found that Bourdieu's conceptual framework also encouraged and directed my thinking towards how my early experiences had significant importance in the formation of habitus.

Primary socialisation for me was a positive experience. I consider my childhood and early years as supportive and warm. The transmission of cultural and economic capital undoubtedly gave me a notion of social order, of right and wrong, and gave me a sense of place in the world. This sense of place was influenced by my parents' own social place; neither were considered to be academic, my father being a salesman and my mother a care worker. Crucially, however, my mother in particular encouraged my interest in nursing. She herself had trained as an orthopaedic nurse, but had not completed state registration; this she regretted all of her working life, which manifested in many conversations about "the world is your oyster" when I became a state registered nurse. My educational journey involved the 11+ examination which I failed; interestingly, I cannot remember how I felt at the time, however I believe the legacy of the 11+ failure has resonated through my adult life and has been manifested in a need to succeed. As I was an only child, my parents invested all of their hopes for the future in me, and as an adult I have always strived to make them proud which I know they are. Unknowingly, however, I have been enacting Bourdieu's concept of cultural capital as I seek to eradicate my past and replace this with externally validated prizes in the form of professional and academic qualifications. Qualifications and experience act as accumulated history and when viewed as cultural capital they can be viewed as giving me a social advantage in the field. My mother holds dear my professional qualifications and I am proud to be a nurse. However, having reflected in Bourdieusian terms I ponder whether subconsciously the title of Doctor has become the ultimate symbolic prize, one in which I see both cultural and symbolic capital conjoining to present to the world a rebirth of my embodied self.

Introduction/background

Specialist Community Public Health Nurses comprise nurses on the third part of the NMC register and include health visitors (HV), occupational health nurses and school nurses. Prior to the release of the NMC (2018b) standards for student supervision and assessment, the NMC (2008) standards to support learning and assessment in practice set out the requirement that all students undertaking a programme leading to registration as SCPHN were placed with a Practice Teacher (PT) who was

responsible for the design, delivery and assessment of programmes of learning in practice settings. HVs are charged with leading and delivering the Healthy Child Programme (HCP), *Pregnancy and the first five years of life* (Department of Health [DH], 2009), the focus of which is early promotion of public health. The HV works in collaboration with midwives who deliver the HCP during pregnancy and the neonatal period, and with school nurses who are key to the delivery of the HCP for the 5-19 years' age group. HVs are recognised as highly trained public health nurses (NICE, 2014), who work with families to support them during the crucial early years of childhood (Cowley et al., 2013).

Historically, there has been much debate concerning the role and purpose of health visiting (Cowley, Buttigieg, & Houston, 2000). Health visiting as a field of practice is seen to overlap into other related professions including nursing, education and social work; consequently, the role of the health visitor has proved difficult to define and has been in a state of flux since its inception in the mid-19th century (Baldwin, 2012). The first example of health visiting was the Manchester and Salford Ladies' Sanitary Reform Association (1862), originating through the philanthropic Victorian public health movement aimed at the poor and working classes. This voluntary organisation employed respectable working-class women alongside lady volunteers of the sanitary reform movement to work in deprived areas as a response to high infant mortality rates amongst the poor (Dingwall, 1977). Their remit was to educate and support working class mothers, and in so doing act as health regulators of the poor, combining the roles of inspector, social worker and teacher (Symonds, 1991).

In the early twentieth century, a declining birth-rate and a concern for the survival of infants prompted government sponsorship of HVs which were employed by local authorities across the country. In 1907 following the Notification of Births Act, HVs were ordered by statute to visit all newly delivered mothers to increase survival rates for both mother and child. Their duties were also extended to include visiting pregnant women and children until they reached school age (Baldwin, 2012). In neoliberalist terms, the family and in particular mothers were becoming increasingly managed in order to address infant mortality rates, rather than the politically challenging public health issues of the time (Burrell, 2011; DeSouza, 2013). This period of history heralded a change in political and scientific ideology towards motherhood and child-rearing, culminating in universal surveillance of mothers and families (Jewson, Unwin, Felstead, Fuller, & Kakavelakis, 2008). Ultimately the health visiting role became increasingly dichotomous, offering advice and support to families whilst also acting as mechanisms of surveillance and discipline through the monitoring of child

development and parenting practices, drawing parallels with the Foucauldian concept of surveillance (Malone, 2000; Peckover, 2002).

A crucial point in health visiting history was the transfer from local authority control into the National Health Service (NHS) in 1974; this resulted in strengthening a medical model of care delivery, reducing the HV role in preventive public health as HVs became increasingly interlinked with nursing. In the 1990s there was an increased recognition of the importance of public health approaches in key policy documents such as: *The health of the nation* (DH, 1992), *The new NHS; Modern, dependable* (DH, 1997), and the *Acheson report* (DH, 1998). HVs were subsequently charged with the task of leading community development with a renewed public health focus alongside individual surveillance. Subsequently, the HV role became increasingly broad incorporating individual and family health and population based approaches to public health (Cowley & Frost, 2006), resulting in the primary purpose of health visiting becoming difficult to define (DH, 2007). Significantly, up until 2001 health visiting was regulated as a separate profession to nursing and midwifery; however, the Nursing and Midwifery Order of 2001 removed health visiting from statute with the result of the closure of the HV register in 2004 and the title no longer having legal and professional currency. This is seen as key to a loss of professional identity, the subsequent decrease in HV numbers, and the introduction of dilute skill mix models (Institute of Health Visiting, 2014).

Since originating in 1862 the development, direction and remit of the health visiting profession have been shaped by the dominant political discourse of the time. Table 1 illustrates the key milestones over the last 44 years and how these have impacted on the health visiting profession; the table commences in 1974, a key time when health visiting was transferred from local authorities to the NHS.

Table 1: Key developments in health visiting timeline

Date	Key development	Content	Impact
1974	Health visiting services transferred from local authorities to NHS	Strengthens the medical model of care delivery	Separates the PH function of health visiting from other public health workers
1997	Policy *New NHS: Modern and dependable* (DH, 1997)	Recognised the importance of public health approaches	HVs tasked with delivering new PH focus
1998	Policy *Health of the nation* (DH, 1998)	Recognised the importance of public health approaches	HVs tasked with delivering new PH focus
1998	*Acheson report* (DH, 1998)	Recognised the importance of public health approaches	HVs tasked with delivering new PH focus
2001	Health visiting removed from statute	Closure of the health visitor register	Seen as having a negative impact upon professional identity
2008	NMC standards for supporting learning and assessment published (NMC, 2008)	All SCPHN students to have a qualified stage three PT	PTs were assigned to students on a one-to-one basis
2009	PHE *Healthy child programme* published (DH, 2009)	Key universal PH service for improving health and well-being of children	HVs charged with leading and delivering this programme
2010	*Field report: The foundation years* published (Field, 2010)	Advocated funding to be directed towards early years	HVs cited as key to government anti-poverty strategy
2010	*Marmot report* published (Marmot, 2010)	Called for action across the social gradient to reduce health inequalities	Every child best start in life
2011	*Tickell review* published (Tickell, 2011)	First years highlighted as fundamental to health and development	Strengthened the role of health visitors in child development and early years settings
2011	*Allen report* on early intervention published (Allen, 2011)	Introduced concept of the Family Nurse Partnership advocating intensive support for new mothers	Expanded the role of health visitors further

Date	Key development	Content	Impact
2011	*Munro review* into child protection published (DfE, 2011)	Endorsed improvements in the health visiting service including their role in safeguarding children	Advocated safeguarding supervision for health visitors
2011	*Health visitor implementation plan* launched (DH, 2011a)	Government response to recent key documents focusing on early years	Government commit to train 4200 HVs by 2015, Seen as a critical moment in the profession's history
2011	NMC announce mentorship arrangements to support HVIP (NMC, 2011)	Mentorship models changed to accommodate unprecedented numbers of student HVs.	PTs to act as long arm mentors to students placed with a stage two mentor
2012	*Health and Social Care Bill* published (Gov.UK, 2012)	Radical reform of NHS	Significant milestones for HVs as they move back to LA, strengthening PH approaches to care
2012	HEIs begin to offer accelerated training programmes for health visitors	Emergence of new training routes such as bolt-on and 2+1 students	Students less experienced, including RGNs who had undertaken a shortened pre-registration programme
2014	NHS England publishes its *Five year forward review* (NHS England, 2014)	Radical upgrade in preventive services	Health visitors cited as making a key contribution
2017	Changes to funding of CPD courses	20% reduction in funding for CPD courses	Cuts to CPD funding that LETBs provide to train qualified people to become clinical mentors
2018	NMC release new standards for student supervision and assessment (NMC, 2018b)	New roles of supervisor, practice assessor and academic assessor	Formalised mentorship programmes no longer a requirement. Preparation will be left to local interpretation

Recent key policy documents

Between 2010 and 2011 a number of key documents were published which have directly impacted upon the health visiting profession. In 2010 Frank Field, MP for Birkenhead, was commissioned by the Prime Minister, David Cameron, to provide an independent review on poverty and the life chances for children. The resulting report, *The foundation years: Preventing poor children becoming poor adult*s (Field, 2010), aimed to reshape an anti-poverty strategy and proposed a shift of focus towards addressing factors that affect life chances, such as healthy pregnancies, positive parenting, educational attainment and quality childcare. The review drew upon evidence from neurological and social science, presenting the case for early support in childhood as pivotal to a child's development. Recommendations called for a redirection of government funding towards early years, weighted toward the most disadvantaged children. HVs were cited as key workers in the anti-poverty strategy, undertaking the complex task of engaging and supporting vulnerable families and leading professional and voluntary workers through Sure Start centres.[3] The Marmot Review, *Fair society, healthy lives* (Marmot, 2010), proposed the most effective evidence-based strategies for reducing health inequalities in England from 2010 onwards, arguing for government policy focused on reducing inequalities in health across the social gradient. Marmot's two policy goals – to maximise individual and community potential; and to ensure social justice, health and sustainability – recognised the importance of early intervention in improving health and social inequality outcomes throughout life.

A further report led by Dame Claire Tickell, *The early years: Foundations for life, health and learning* (Tickell, 2011), concluded that the first years of a child's life are fundamentally significant. The report recommended that children should undergo a developmental check as part of the Healthy Child Programme (HCP)[4] by early years' practitioners at two to two-and-a-half years, alongside the HV check.

This was to identify developmental delay in children and strengthen communication channels between the health visiting service, parents and early years' educational settings. Graham Allen's (2011) report, *Early intervention – The next steps*, also argued that early intervention offers real opportunities to make lasting improvements

[3] Sure Start children's centres are settings managed by local authorities delivering early childhood services. Their core purpose is to improve outcomes for young children and families.

[4] The HCP is a universal 0-19 framework to support integrated children's services. The programme recognises early intervention as key to good health, well-being and resilience. The 0-5 element of the HCP is led by health visiting services.

to the lives of children. The report provided strong evidence that the Family Nurse Partnership (FNP) Programme[5] was having positive outcomes for vulnerable children and their families. As a consequence, the government extended the programme which offers structured home visiting centred on attachment, relationships and lifestyles, and also its commitment to expanding the number of HVs able to undertake early intervention work (RCN, 2011a). Also in 2011, Professor Eileen Munro published a review of child protection (DfE, 2011) in which early identification of problems and the timely provision of help were seen as paramount. The report emphasised the significance of multi-agency services which deliver support for families, which was seen as vital in promoting children's well-being, and endorsed improvements in family support services including Sure Start and the HV service.

Health Visitor Implementation Plan

Crucially, all of the reports highlighted the significance of effective collaborative services and early support for children and families. However, whilst acknowledging the broad consensus that HVs should continue to lead the delivery of the HCP 0-5 years provision, there was also growing recognition that a lack of capacity in HV services was restricting the profession's ability to deliver effective preventive services (Lancet, 2011). As a consequence, universal contacts were frequently curtailed in favour of targeted delivery models (Wood, Stockton, & Brown, 2013). A review of the health visiting service in England culminated in a recruitment campaign and revitalisation of the health visiting service through the Health Visitor Implementation Plan (HVIP) (DH, 2011a, 2011b). In 2011 the Coalition Government led by David Cameron made a challenging and unprecedented commitment to an extra 4,200 HVs by 2015. The HVIP stated that the health visiting service would be a key part of the response to the challenges highlighted by Field (2010), Tickell (2011), Allen (2011), Marmot (2010) and Munro (DfE, 2011). According to Cheryl Adams (Director of the Institute of Health Visiting, UK), this was a critical moment in the profession's history (C. Adams, 2011).

Whilst the HVIP recognised the importance of early intervention in order to improve the life chances of children, it also had the potential to affect the professional identity of health visiting as the planned rapid expansion had a radical impact upon recruitment and the demography of the workforce. This resulted in the profession undergoing a fundamental shift in personnel from a workforce which previously

[5] FNP is an intensive home visiting programme aimed at parents aged 24 and under, partnering families with a specially trained family nurse who visits regularly, from early pregnancy until their child is two.

consisted of largely older, experienced, white females (Greenway, Dieppe, Entwistle, & Meulen, 2008) to a workforce which would consist of 50% newly qualified health visitors by 2015 (Centre for Workforce Intelligence, 2012). Whilst the HVIP was seen to reinvigorate the profession, the biggest criticism of the policy was its radical impact on HV demography and the challenges PTs faced when trying to support unprecedented numbers of students entering the programme (Bayliss-Pratt, 2015). Another significant development was the Health and Social Care bill (Gov.uk, 2012), which dictated that health visiting should be removed from the NHS structure and sit once more within public health departments under the auspices of the local authority. This was seen as a renewed opportunity for HVs to offer their expertise in the planning and delivery of public health services, including the crucial link between poverty and poor health outcomes. There were concerns that the HVIP and the increase in HV numbers on their own would not be able to address issues of social mobility and child poverty, with PTs becoming burnt out as a result of supporting many students (Naughton, 2013).

Whilst key documents published in the early part of the 21st century recognised the significance of early years' intervention, calling for redirection of funding to redress the balance in social inequality, the dominant political discourse of the time can be viewed as largely ignoring the fundamental issues of social inequality, including adequate funding and wider socio-political ideology. The relatively small increase in HV numbers fits with the principle tenet of neoliberalism which is minimal government intervention. Healthcare is a political issue, and the extent to which health visiting and the nursing profession may become disempowered through neoliberalist policies is discussed in more detail later in this chapter. However, it is important to recognise at this point that the professional identity and breadth of the HV role were being influenced once more by political manifesto. Health visiting was removed from the NHS and from the medical model which had dominated the profession since 1974 when the responsibility for commissioning health visiting was transferred from NHS England to local authorities in October 2015.

The impact of the HVIP

In a bid to meet the demands of the HVIP several higher education institutes (HEIs), offered accelerated training routes such as '2+1' programmes, where a graduate with a health related degree could obtain APL (accreditation of prior learning) and complete their pre-registration nurse training in two rather than three years, leading to first level registration. This was followed by a one-year post-registration SCPHN-

HV programme (Haydock & Evers, 2014). The HVIP set out a new practice education agenda, requiring innovative flexible approaches to training and development (DH, 2011c); however, Brook, Salmon, Kimberlee, Orme, and Bird (2014) argue that the short timescale in which it was implemented was problematic, including how the additional students would be trained and supported. Prior to the HVIP, the one-to-one mentorship model – one student assigned to one PT for the duration of the programme (NMC, 2008) – had been the practice education model of choice. Following the HVIP, new models of practice education emerged in order to manage the increasing numbers of HV students (Bayliss-Pratt, 2015). Such models included the PT supporting up to three trainee PTs or mentors who supported the students' educational placement on a day-to-day basis (NMC, 2011), and a further model known as a peripatetic 'roving' model was developed in the East of England. The roving model involved the PT overseeing up to six students and assigned mentors (Devlin & Mitcheson, 2013), which necessitated a reduced PT clinical caseload in order to facilitate placements and support mentors. Long arm mentorship (LAM) models resulted in PTs being responsible for signing-off to the NMC numerous students without the day-to-day contact associated with the one-to-one model, sometimes across wide geographical areas (Devlin, Adams, Hall, & Watts, 2014). Whilst new practice education models can be viewed as innovative, there has been limited empirical research which explores and evaluates the LAM models from the PT, mentor and student perspectives.

Nurse education

In May 2018 as the final chapter was being written for this thesis, the NMC released new standards for student supervision and assessment for all United Kingdom providers of nursing and midwifery education (NMC, 2018b). The standards are for both pre-registration and post-registration nurse education programmes (NMC, 2017a) and replace the 2008 standards from 2019 onwards. The standards set out new roles within practice education: practice supervisors, who will be registered health and social care professionals who facilitate learning and contribute to student assessment decisions; and nominated practice assessors, who are on the same part of the NMC register that the student intends to join, and who will confirm the achievement of competency. The third new role is that of nominated academic assessors of practice. Academic assessors are required to be on the same part of the register that the student intends to join, and they will also contribute to the assessment and confirmation of student learning and competency. At the time of writing, the implications of the new standards for HV education are unknown;

however, it is suggested that the PT role will become that of nominated practice assessor and the mentor role will become the practice supervisor role. Programme leaders for SCPHN will most likely assume the role of academic assessor. It is as yet unclear how each of these roles will be interpreted locally as the NMC standards suggest flexibility, with the caveat that the roles are applied to all approved programmes. The new NMC (2018b) standards are evaluated in more detail later in this chapter and in the discussion chapter in relation to the findings from the research and the possible implications for health visiting and wider nurse education.

Health visiting is inextricably linked to pre-registration preparation, being predicated on the successful completion of a pre-registration programme (iHV, 2015). Although the main focus of this professional doctorate concerns health visiting practice education, it is important to contextualise this thesis within the socio-political climate of the time and the broader evidence base and context of the field of nurse education. This broader perspective, coupled with an understanding of both the historical beginnings of health visiting and evolving health visiting practice education, will also facilitate the emergence of a conceptual framework based upon the key concepts emerging from literature, policy and research. Similar to health visiting, the development and reform of nurse education have been shaped and influenced through policy and evolving health service provision. The state of the economy is a pervading issue for the NHS, made more problematic as care costs increase and individuals live longer, frequently with increasing co-morbidities (Zhang & Lathlean, 2014). Nursing curricula are designed around political and societal change, technological advances, individual expectations and perceptions of health, all of which impact on the ever-evolving nurse role (Zhang & Lathlean, 2014). Table 2 illustrates the key milestones in nursing over the last 35 years and how these have impacted on the nursing profession. The table commences in 1983 when the United Kingdom Central Council for Nursing, Midwifery and Health Visiting developed a new professional register with four branches: adult, child, mental health and learning disability.

Historically, approaches to nurse education centred on apprenticeship models, a legacy of a religious past within monastery/convent communities. The development of secular nursing is invariably linked to Florence Nightingale with the formation of the first training school for nurses. Trainees learned skills within a hospital setting, an abiding framework which has been replicated for over 150 years. Contrary to popular belief, Florence Nightingale herself considered nurse education should be independent from hospital funding and fiscal control (Stewart, 1943). Prior to 1993,

student nurses were salaried members of the workforce contributing to service delivery; this was a vocational model of training, open to individuals with varying academic qualifications (Carpenter, Glasper, Jowett, & Nicholls, 2012). The apprenticeship model dominated the 1980s; however, concerns were raised including how training was managed and the employment status of student nurses. This resulted in the Royal College of Nursing (RCN) calling for the uncoupling of education from the direct and persistent control by service (RCN, 2007) and more universities began to offer nursing degree programmes.

Launched in the 1980s, Project 2000 revolutionised nurse training, heralding the mass transfer of nurse education from the apprenticeship model to a model of education within a university context (Zhang & Lathlean, 2014). Project 2000 was operational from 1993: the State Enrolled Nurse qualification was phased out and nurses graduated with a diploma in higher education alongside a registerable professional qualification. Continued research and evaluation into the success of Project 2000 resulted in further revisions to nursing programmes. Project 2000 was initially structured with 80% theory and 20% practice, and this was changed to a 50/50 mix to strengthen clinical skills and competency at the point of registration. Action was taken to attenuate the tensions becoming apparent between healthcare employers and educationalists (Cowan, Norman, & Coopamah, 2005), reflected in the policy *Modernising nursing careers* (MNC) (DH, 2006) which focused on pre-registration nurse education and the changes required to develop a competent and flexible workforce. Resultant revisions included emphasis on clinical skills and competencies with the development of leaders in education and research to bridge the divisions between service based and academic careers. This included the emergence of the 'practice education facilitator' role to support skill acquisition in practice. MNC was welcomed as a forward thinking policy; however, the shifting political landscape at the time meant that the developmental framework fell short of its potential (Rafferty, Xyrichis, & Caldwell, 2015). Although a move to raise the educational status of nurses in line with other professions was seen as paramount, skills and competencies were given precedence by employers, and the debate between the needs of service and the effective education of nurses continued throughout this period.

Table 2: Key developments in nursing timeline (post-1983)

Year	Key developments	Content	Impact
1983	United Kingdom Central Council (UKCC) for Nursing, Midwifery and Health Visiting develops a new professional register with four branches	Branches for adult, mental health, learning disability and child are established.	This differs to European countries where branches other than adult are post-registration qualifications.
1986	Project 2000 sets out the move to diploma level nurse training (UKCC, 1986)	Nurse education moves away from hospital settings and education delivered in college/university	Places emphasis and value on academic knowledge as well as skill acquisition
1999	*Making a difference* paper published (DH, 1999)	Call for stronger links between universities and the NHS. Education was to focus on the skills and services needed by patients and clients	Introduction of a one-year competency-based common foundation programme followed by a two-year branch programme.
2002	DH publish *Extending independent nurse prescribing within the NHS in England* (DH, 2002)	Specialist practitioners, nurse consultants and other experienced nurses with at least three years' experience receive additional training	Limited Formulary implemented which was subsequently criticised as not covering prescribing needs
2002	Nursing and Midwifery Council takes over from UKCC defining the scope of practice and codes of ethics	National boards are disbanded for each of the UK countries	NMC as regulator for nurses and midwives also monitors the quality of nursing and midwifery education courses
2004	RCN votes for degree-only preparation	All graduate training seen as giving equal status with other professions	Backlash in the media that nurses would be 'too posh to wash'
2004	*Standards of proficiency for pre-registration nursing education* published (NMC, 2004b)	NMC sets up three parts to the register for nurses, midwives and SCPHN	In accordance with EU programmes, pre-registration training is 4,600 hours in length. Continuing Professional Development (CPD) and PREP introduced
2006	*Modernising nursing careers: Setting the direction* published (DH, 2006)	Four key elements identified to meet changing demands: practice; education, training and development; quality and service development; leadership, management and supervision	Government approval for degree level education for registered nurses. Introduction of preceptorship framework. Focus on local application through work-based learning

Year	Key developments	Content	Impact
2007	Essential skills clusters (ESC) for pre-registration nursing programmes introduced (NMC, 2007)	Response following the review of fitness for practice at the point of registration	Introduction of UK-wide generic skills statements including compassion, communication, organisation, infection control, nutrition/fluid maintenance, and medicines management
2008	NMC release new standards for supporting learning and assessment (NMC, 2008)	Set out specific outcomes for mentors, practice teachers and teachers	Students had to be supported and assessed by mentors. Introduction of sign-off mentor, for final assessment and confirmation of proficiencies
2010	*Standards for Pre-Registration Nurse Education* published (NMC, 2010a)	Degree in Nursing as minimum award. Flexible approach to placements providing they support competency attainment	Competency framework based on four domains, generic and field specific (adult, child, learning disability and mental health) knowledge and skill competencies
2012	Health and Social Care Bill published (Gov.UK, 2012)	Radical reform of NHS	The RCN raises concerns regarding public health workforce planning and education which are given little mention
2013	*Francis report* released (Francis, 2013).	Examination into the failings in care at Mid-Staffordshire NHS Foundation Trust	290 recommendations including nurse training, education and professional development. Emphasis on compassionate care, with frontline nursing leadership
2014	NHS England publishes its *Five year forward review* (NHS England, 2014)	Radical upgrade in preventive services and flexible models of service delivery. Integration and leadership seen as crucial	*Five year forward: Next steps* 2017 introduces fast track post-graduate recruitment and training
2015	Conservative Chancellor announces the removal of the cap on the number of nursing places and a change to the funding system	Government-funded nurse bursaries to be replaced with student loans from 2017	Recent figures up to mid-January 2017 show 10,000 fewer applicants from England, a fall of 23%

Year	Key developments	Content	Impact
2015	*Shape of caring review – Raising the bar* published (HEE, 2015)	Consistent standards for HCA to be introduced. Developing high-quality mentorship and improving practical learning experiences	Acquisition of advanced skills to be included in pre-registration programme. Greater decision-making skills and application of research and innovation
2018	NMC release new standards of proficiency for registered nurses and standards for student supervision and assessment (NMC, 2018a, 2018b)	Four fields remain, with exposure to all fields across settings. New roles of supervisor, practice assessor and academic assessor	Emphasis on enhanced knowledge, leadership and skills, elements of prescribing to be included. Formalised mentorship programmes no longer required, local preparation

During the early part of the 21st Century, the way educational programmes were structured continued to be viewed as an uneasy compromise between education and the provision of a nursing workforce (Cowan et al., 2005). The future and direction of nurse education raised strong public opinions, with media headlines such as “too posh to wash” fuelling the debate (Scott, 2004). Such headlines highlighted the tensions and polarised opinion between skills based training and an academic educational approach. Despite the ongoing discussion, in 2013 the diploma of higher education was superseded by a degree, creating an all-graduate entry to the profession. This change focused on raising nurse education to the same standard as other health related professions (Carpenter et al., 2012), and can be viewed as part of a gradual evolutionary process in modernising nursing, aimed at the development of advanced leadership and decision making skills (DH, 2010; RCN, 2007). Despite the earlier concerns raised with regards to nurses being over-educated, the *Willis report* published in 2012 (RCN, 2012) indicated that a graduate workforce was key to governance and raising overall standards of care, reinforcing the relevance of university education. More recently, undergraduate and advanced degrees have been linked to competencies such as critical thinking skills, leadership abilities, and the importance of quality care and decision making (Aiken, Rafferty, & Sermeus, 2014; Hofler, 2016).

Health policy more recently has focused on the development of hybrid roles and the leadership of integrated pathways across acute and primary care settings and organisational boundaries (NHS England, 2014). This is in response to the increasing complexity of community care and problems with GP recruitment and retention, with the upskilling of nurses viewed as a solution to increasing service demands (Rafferty et al., 2015). Whilst the importance of an educated skilled nursing workforce is emphasised in the *Five year forward review*, at the same time the *Shape of caring review* (HEE, 2015), published in response to high-profile national reports such as the *Francis report* (Francis, 2013), called for patient-centred, compassionate care. The *Francis report* fundamentally influenced the public’s perception of nurses and their inability to ‘care’. As a direct consequence there was a loss of esteem for the profession, at a time when the work of the nurse was becoming increasingly complex, stressful and often unrewarding (McKeown & Carey, 2015). These key policies would seem to reflect the dichotomy between the value placed upon the traditional vocational caring role associated with nursing (Cooke & Philpin, 2008) versus technical, scientific and education-focused outcomes (Carpenter et al., 2012). According to Hutchinson (2015), this has the potential to denigrate the concept of

nursing knowledge and professional identity, as nurses are targeted as scapegoats for the moral panic around healthcare provision.

The political agenda: Contextualising HV and nurse education

Since its inception 70 years ago, the NHS and politics have been inextricably linked. Government policy and the distribution of NHS funding streams are structuring processes on health and social care services. Ham (2017) argues that the NHS crisis is political, not humanitarian, with all political parties guilty of failing to provide sufficient funding for health and social care. Neoliberalism is the foremost form of governance in countries across the world and the primary ideology driving current healthcare delivery (Eliason, 2015; Peters, 2001). Neoliberalism, although often associated with right wing politics, pervades all party politics; indeed, Mudge (2008) argues that neoliberal leanings have entered into mainstream politics since the Seventies with the adoption of market-friendly politics. A neoliberalist lens can therefore be used to explore the current political climate.

Neoliberalism is a relatively new concept, developed by Chicago economists during the 1960s and 1970s. In the United Kingdom, neoliberalism as a system of government emerged when Margaret Thatcher was Prime Minister (Grant, 2014). During the 1980s Thatcher commenced the withdrawal of central capital control, the principal tenet of neoliberalism being that of minimal intervention at government level, concerned with individualism, decentralisation, privatisation and deregulation, with market forces being the determining factor in service provision (McGregor, 2001). Healthcare as previously stated is a political issue, and the extent to which the nursing profession has become disempowered through government policies is critical to nursing education (Eliason, 2015). Political policies frequently define healthcare as a product which can be delivered by any market competitor; services are increasingly fragmented, devolved and underfunded, as fiscal responsibility dominates policy making (Brown & Szeman, 2000; UK National Advisory Board to the Social Impact Investment Taskforce, 2014). In a bid to resolve the issues highlighted in the *Francis report* (2013), the *Shape of caring review* (HEE, 2015) called for a focus on caring including the effectiveness of nurse training and the preparation of healthcare assistants. Key recommendations were: enhanced leadership; flexible models of education; more value placed upon the healthcare assistant role; the development of a care certificate; pre-degree care experience; and development of higher apprenticeship routes into pre-registration nursing. Viewed through a neoliberal lens, the *Shape of Caring review* (HEE, 2015) could be interpreted as government's

attempt to meet expanding complex healthcare needs and the expectations of service by widening access to nursing, returning it to vocational values. Critics argue that the review shifts attention from inadequate funding and issues of poor care to a focus on professional change particularly aimed at the nursing profession (Hutchinson, 2015). This largely ignores the fundamental issues which underpinned the failures highlighted in the *Francis report,* suggesting healthcare can be improved without additional financial resources (Selberg, 2013).

Post-Francis, politicians are keen to adopt a position where issues are identified and resolved centrally through policy direction, but funding decisions are devolved to local commission level, often not translating into service implementation (McGregor, 2001; McKeown & Carey, 2015; Rafferty et al., 2015). Post-Francis, the leading narrative was one of nurses being uncaring and dispassionate, promoting a view that nursing is in crisis requiring reform and further regulation (Hutchinson, 2015). Nurse education is seen as key in redressing such criticisms; however, this stance fails to acknowledge the socio-political environment in which nurses work. Selberg (2013) argues that the complex and demanding healthcare environment stemming from a power shift from professionals to policy makers and auditors results in dissatisfaction and ultimately burnout (Grant, 2014). Nurses report difficulties trying to balance the frequently differing demands of managers and patients whilst delivering care that meets the standards taught in training (Selberg, 2013). McKeown and Carey (2015) refer to the degradation of healthcare work associated with neoliberal efficiencies, with public services undervalued and under resourced, resulting in a nursing workforce which is disempowered and unable to lead and exert influence. There are alternative views, however, which consider the opportunities which have arisen for nurses as a direct result of devolved services and advanced nursing roles. Entrepreneurship in nursing according to Yeliz, Nuray and Hatice (2017) was made possible as a consequence of societal changes which allow space for new nursing initiatives within the field. New career pathways are seen as development opportunities which may enhance careers and improve patient care (Bayliss-Pratt, 2016). However, as future demands on the health service increase a further pressure on the nursing profession is the development of advanced practice skills (Rafferty et al., 2015). Crucially, the new NMC standards of proficiency for registered nurses (NMC, 2017a, item 7, annexe 2; NMC, 2018a) state that from 2019 pre-registration training will be expanded to include skills, knowledge and competencies once previously considered the remit of post-registration qualification frameworks. Positively, according to the NMC standards new graduate nurses will be able to provide high quality patient centred care at the point

of registration (NMC, 2017a, 2018a). Alternatively, the NMC response to employer influence can be viewed as contributing to neoliberalist ideals which place value on ever-increasing technical skills as opposed to higher level thinking. A skilled workforce at the point of registration is seen as more cost-effective than the option of developing post-registration skills through continuing professional development frameworks built upon throughout nursing careers. CPD is interpreted as problematic in the current political climate as it would seem that learning is valued only when considered in terms of marketable workers who learn in order to secure employment. This has resulted in cuts of up to 45% in training budgets; crucially, however, funding for postgraduate medical education has continued to be protected (Council of Deans for Health, 2016c). The concept of lifelong learning ensures nurses assume the responsibility of remaining current, marketable and flexible; however, as funding is reduced health providers have effectively removed themselves from this responsibility (Butcher & Bruce, 2016).

The new NMC standards of proficiency for registered nurses (NMC, 2018a) appear to add to a demanding curriculum, reducing space for deep learning which educationalists argue is the real value of university education (Inglis, 2016). The NMC can be viewed as challenging the very concept of intellectual independence as they regulate nursing curricula, creating tension between the pursuit of knowledge and a notion of neoliberalist productivity (Pringle, 2016). Within the context of nursing and HV education, a concentration on attainment of competencies and skills is an example of the current political agenda which can be considered to view technical ability over the generation of new knowledge. The true value of a university education as a creator of knowledge for social good (Inglis, 2016) may be seen as less significant than the creation of a nurse with the skills to function as a useful member of the healthcare team. Critics argue for an ontological shift in nurse education which moves away from external influences and a focus on skills, to one concerned with the embodiment of knowledge (Butcher & Bruce, 2016). Grant (2014) urges academics to consider their historical and cultural location in order to critically engage and challenge political agendas where transmission of knowledge eclipses scholarship and knowledge creation. The introduction of tuition fees for nursing students may make this difficult, as nurse academics function in an increasingly competitive higher education sector which will compound the importance of economic outcomes. In neoliberalist terms, the student adopts the role of consumer, with knowledge an outcome rather than a process in itself (Inglis, 2016). Performance indicators in the form of league tables add further pressure on universities: students are able to select

a place of study based on league positions, increasing competition between universities striving to improve their ranking. Selection based on league table data alone is problematic as programmes of study may be well regarded by local stakeholders irrespective of position on league tables (Hazelkorn, 2006). Recent HE policy includes the introduction of the government-run Teaching Excellence Framework (TEF) (Gov.uk, 2016), introduced to promote excellence in teaching and redress the balance between research and teaching (Willets, 2013). TEF measures six metrics across three categories: teaching quality, learning environment, and student outcomes and learning gain. Concerns have been raised about how teaching excellence is measured as the metrics are based on student satisfaction, retention and employment with positive TEF results influencing the course fees, further marketising higher education (Harris, 2017).

Emerging developments

Through 2017 and 2018 there have been key changes in nurse education. The abolition of the training bursary announced in the Autumn Statement of 2015 (Gov.uk, 2015) came into force from August 2017. The DH spends £826m a year funding 60,000 student nurses in England and the changes to nurse education funding are seen as a way for government to divert resources to meet rising NHS costs (Hubble, Foster, & Bolton, 2017). The reform was to release a further 10,000 additional nursing and health professional training places, lifting the cap on the number of student places for nursing, midwifery and allied health professions. The Council of Deans of Health (2015a) argued for the changes, as removing the cap on the number of places meant more people could pursue a nursing career. Other supporters welcomed the reform with the caveat that the fees accrued could be repaid by Health Education England (HEE) if nurses were subsequently employed by the NHS (Stubbs, 2015). Critics argued that the true cost of a nursing degree would amount to £65,000, deterring potential students from entering a career such as nursing which had poor pay and prospects (RCM, 2015; RCN, 2016). Current trends indicate that the critics' worst fears are being confirmed: recent UCAS figures (RCN, 2017) show student applications to UK higher education are down by 5% with a further 7% reduction for EU students, possibly as a result of current BREXIT negotiations. Nursing saw the largest decline, falling 23%; applications from older groups fell between 6% and 29%, set against a backdrop of a 96% reduction in nurses from EU countries registering to practise in the UK and 40,000 nursing vacancies in England (RCN, 2017).

In December 2015 following the recommendations in the *Shape of caring review,* HEE announced plans to create test sites for a two year nursing associate (NA) NMC regulated training programme. Viewed as a positive workforce development, this significant change in nurse education was designed to enable the registered nurse in England to focus on complex need and treatment whilst the NA delivers the practical hands-on care (Cummings, 2016). The concept of a support role in nursing is not new, having undergone previous incarnations known by various titles (Cavendish, 2013). Previously, the enrolled nurse acted as another level of nurse within the UK, constituting one third of all qualified nurses; the phasing out of the role resulted in an overall reduction in the number of qualified nurses (Health Foundation, 2016). The NA role is a mechanism to widen nurse recruitment and bridge the gap between the nurse graduate and the care assistant; however, there is a risk of role confusion as there already exist assistant practitioners and varying levels of care assistant. The role can also be seen as adding another layer of complexity for registered nurses who will find themselves acting as managers and supervisors of a myriad of workers, rather than delivering care themselves. Whilst it is argued that the NA role will provide opportunities for skill development and progression on to registered nurse training, there is no additional funding for the initiative (Ball, 2016). Critics consider that unless funding for training becomes available, the NA role is unlikely to become an important part of the workforce (Health Foundation, 2016). Crucially, the Council of Deans for Health (2017) draw attention to the issues of transferability from apprenticeship routes into nursing, as frequently some learners having undertaken work-based learning routes fail to meet literacy, numeracy and critical thinking skills which are essential requirements for nursing.

At the same time as the NA role was launched the government also announced the nursing degree apprenticeship, with plans for 1000 apprentice nurses joining the NHS yearly. Funded by the Skills Funding Agency, apprenticeships are viewed as flexible work-based programmes which trainees join at varying stages dependent on qualifications and experience. This is seen by policy makers as part of the widening access to nursing reported in the *Cavendish review* (2013) and *Shape of caring review* (HEE, 2015). The apprenticeship model is another example of devolved policy including decisions with regards to funding. However, although some elements can be locally determined there are strict regulations concerning apprenticeships which need to be adhered to nationally, including the issue of supernumerary status whilst also meeting the requirement to work as an apprentice for the minimum of 30 hours a week (Council of Deans for Health, 2016b). As funding for apprenticeships will be

determined locally, the numbers of apprentice nurses and HVs commissioned in the future will be difficult to determine, and employers under new funding reforms will be free to purchase education from any education provider. This is another example of the political agenda impacting upon nurse education as universities are forced into increasingly market-based models of provision.

Whilst it is apparent that there will be different types of learner within healthcare settings, the new NMC standards for student supervision and assessment (NMC, 2017a, item 7, annexe 2; NMC, 2018b) set out changes for the mentorship of learners from 2019 onwards. These changes come at a time when student nurses are expected to qualify with advanced clinical and leadership skills, and there will be various learners in the workplace requiring support including NAs and apprentice nurses. The NMC (2018b) standards state that individuals supporting practice learning will no longer require formal training, and that the preparation of the new roles of supervisor and assessor can be locally determined. The new standards manifest as liberating practice learning environments as requirements will not be as constraining; this may afford innovative approaches to practice learning, including any registered healthcare professional being able to act as a supervisor. Whilst acknowledging the freedom to locally determine mentor preparation, in neoliberalist terms the new standards are dismantling national standards of practice education. Concerns raised in the literature with regards to SCPHN practice placements (Devlin et al., 2014) point to variances across the country in regards to how LAM was interpreted. Despite these concerns, it appears that the new standards may result in further variance in provision and potentially differences in the quality of educational support offered to students. The significance of adequate mentorship arrangements was referred to in both the *Willis report* (RCN, 2012) and *Shape of caring* (HEE, 2015), with recommendations made for skilled and motivated mentors. More recently, the Council of Deans for Health (2016a) refer to the challenges of effective practice learning as being a real threat to the delivery of new standards, the professional identity of the students, and their ability to challenge healthcare provision now and in the future. The council called for the NMC to review the lack of value placed on education and mentorship and the focus on input measures such as practice hours. Whilst the new NMC standards of proficiency for registered nurses may be seen as addressing some of the issues raised, it is unclear if the new standards for supervision and assessment will free placement areas to determine innovative models of practice education, or if they will dilute the quality of practice support and education of students. If local preparation and support for mentors are to remain robust across the

country, it is worth considering that in times of neoliberal hegemony, market mechanisms and management techniques deployed are principally concerned with cost reduction (Selberg, 2013).

This chapter has presented an overview of the historical background and development of the health visiting profession, set within the wider context of nurse education and the current political agenda. Key policy drivers have been critically reviewed including the significance and impact of the HVIP (DH, 2011a). The fields of nursing and health visiting have been shown to be affected by historical and political influences including how both professions should be enacted and regulated. As governments form and restructure, there is a resultant impact on the context of healthcare education, including the very purpose of university education in relation to nursing and health visiting. Increasing fiscal austerity measures have resulted in shifting admission criteria, widening access agendas, the development of apprenticeship models and flexible routes to nurse education. Some of these changes are to be welcomed; however, they all have the potential to affect the identity of the health professional, including what constitutes their role and the role of nurse education. This chapter has considered the wider context of nurse education in which health visiting is located, but the main focus of this enquiry is concerned with the phenomenon of HV practice education. In order to consider this further, it is important to consider the existing specialist literature within this subject area. This necessitated a literature review concerning HV practice education, which is presented next in chapter two.

Historical context of this study

For clarification, this study was undertaken prior to the release of the new Nursing and Midwifery Council (NMC) standards for student supervision and assessment (NMC, 2018b). Prior to the 2018 standards, the involvement of stage three sign-off PTs was a requirement for successful completion of post-registration SCPHN programmes (NMC, 2008).

Organisation and structure of the thesis

Chapter Two outlines the literature review strategy including a critical appraisal of the emergent themes from the literature. Conclusions are drawn from the literature, and used to formulate the study aim and research questions which are introduced at the end of the chapter.

Chapter Three presents the research methodology and method, and the conceptual and theoretical frameworks used. Pierre Bourdieu's theory of practice (Bourdieu, 1977) is introduced as the lens through which the findings are located. A rationale for the study methodology is given, along with a defence of the selected approaches including issues of researcher positionality, research method and data collection processes. Ethical issues are explored alongside the concepts of validity, rigour and reflexivity in relation to Yardley's (2008) evaluative criteria. The chapter concludes with an overview of the interpretivist paradigm and Bourdieu's reflexive epistemology.

Chapter Four presents the findings as an integrated analysis and discussion chapter. Working reflexively, I have used Bourdieu's theory of practice to consider the data from the eight transcribed interviews, viewing this from idiographic and social perspectives which enable connections to be made between the common themes generated.

Chapter Five presents the overall conclusion of the thesis and I reflect upon the clinical and educational implications of the findings, the new knowledge generated, and the methodological implications and limitations of the study. Reflexivity and researcher positionality are considered, along with service provision and implications for further research. The chapter and the thesis conclude with the next steps in my personal and professional journey.

Chapter 2: Literature review

This chapter outlines the literature review strategy including a critical appraisal of the emergent themes from the literature. Conclusions drawn from the literature are used to formulate the study aim and research questions, which are introduced at the end of the chapter.

It has been suggested that phenomenological methodology does not always require an in-depth literature review at the beginning of the study as this has the potential to influence data interpretation (Walcott, 1990). Garratt (2013) takes a different stance, arguing that prior understanding can never be removed from research: in a Heideggerian sense, research is already theoretically overdetermined and therefore there is no such thing as innocent interpretation. For the purpose of this study, a literature review was deemed important as it would facilitate the examination and interpretation of the existing specialist knowledge, providing essential background information. The review enabled consideration of the context of the research area and critical appraisal of the evidence (Hart, 1998; Jesson & Lacey, 2006). This enabled gaps in the literature to be identified, which in turn narrowed the focus of this enquiry and the new knowledge to be generated (Boote & Beile, 2005).

Search strategy

A literature review was conducted using the classic library search: this included electronic internet-based social science databases Cinahl, Medline, Blackwell Synergy, Psychinfo, Wiley, Sage and Proquest. The keywords or combinations of keywords used were: student health visitors, health visitor practice teachers, health visitor mentors, SCPHN practice education and practice placements, SCPHN practice teacher and SCPHN mentor. To aid these combinations, the Boolean operators ‘and’ and ‘or’ were also used (Ely & Scott, 2007). Due to the identified paucity of literature with regards to the specialist area of SCPHN practice education, no date criteria were applied for the majority of the search, and grey literature was included in order to capture policy documents and literature not pertaining to research.[6] There appeared to be no research studies pertaining to 2+1 students. The literature search was UK focused due to the unique nature of the SCPHN role. To ensure the quality of the literature reviewed, all research papers were peer reviewed journal articles. Following the database search, hand searching through the reference

[6] Grey literature is defined as “that which is produced on all levels of government, academics, business and industry in print and electronic formats, but which is not controlled by commercial publishers” (Fourth International Conference on Grey Literature (GL '99), Washington, DC).

lists from selected citations was undertaken; this ensured all relevant papers were reviewed. The information retrieved from each search was then tabulated and synthesised according to identified themes.

Literature findings

The search resulted in 8499 potentially relevant papers. Discussion, research and grey papers were obtained. 51 articles were deemed as warranting further detailed examination as they were directly related to SCPHN-HV. Studies were excluded when the primary focus was pre-registration nursing, as the specific focus of the enquiry concerns SCPHN-HV programmes. 13 research papers including qualitative, quantitative and mixed methods studies were considered to be directly applicable. The 13 papers reviewed provide an overview of primary evidence pertaining to SCPHN practice education (see appendix 5 for the literature search strategy). It is acknowledged that there was a paucity of literature pertaining to HV practice education. Many studies had limitations including small sample sizes and studies confined to one geographical area; however, 13 papers were deemed as applicable to the specialised research enquiry.

Analysis

Assessment of methodological quality

Critical appraisal tools can be utilised to aid the process of judging the quality or credibility of research. Quality criteria such as the Quality Framework (Spencer, Ritchie, Lewis, & Dillon, 2003) and the Critical Appraisal Skills Programme (CASP, 2006) can enable reviewers to be explicit about the decisions they make with regard to rigour and subsequent inclusion in reviews (Dixon-Woods et al., 2007).

Following comparison of the two tools, the CASP tool appeared to be less complex, and was selected. Thirteen papers were critiqued using the tool (see table 3); this provided structure and guidance on theoretical frameworks and methodology, aiding the appraisal of trustworthiness, rigour and quality (CASP, 2013).

Table 3: Summary of CASP tool applied to all 13 papers

Author/date/journal	Title of study	Study type	Main findings	Strengths	Limitations	Implications for practice
Adams, K. (2013) Community Practitioner, 86(10), 20-23	Practice teaching: Professional identity and role recognition	Grounded theory. One-to-one interviews and focus group Purposively selected sample of 21	Role of PT varies within and across organisations This impacts upon professional identity and recognition given to the role	Peer reviewed Concerned SCPHN PTs Examined the role of PT from perspectives of relevant stakeholders Aim of the research was answered and evidenced in the paper	Setting UK only Sample size 21, therefore may not be transferable	Organisations need to develop mechanisms which capture the contribution that PTs make to leading and training students and the wider workforce
Carr, H., & Gidman, J. (2012) Community Practitioner, Feb 85, 2	Juggling the dual role of practitioner and educator: Practice teachers' perceptions	UK mixed method study exploring role of SCPHN and SPC mentors	Students require time to develop leadership and cognitive skills. PTs feel undervalued Limited resources and working overtime were problematic	Peer reviewed Concerns SCPHN PTs. SPSS data demonstrated Aim of research was answered and evidenced in the paper	Small sample size of 15 attending one HEI, therefore findings may not be transferable	Highlighted the need for Trusts and HEIs to recognise and support PTs. Protected time highlighted as an issue and the reduction of clinical caseloads to facilitate mentorship
Deave, T., Novak, C., Brook, J., & Salmon, D. (2017) Community Practitioner, 90(8), 45-47	Evaluation of the specialist community public health nursing peripatetic assessment model	Mixed methodology Anonymous online survey and individual interviews or focus groups	Students well supported, though some unconfident in PTs ability to assess Mentors and PT found role difficult Mentors felt lack of recognition Model up-skilled workforce	Peer reviewed Concerned SCPHN HV and HVIP Evaluation of a peripatetic assessment model involving practice teachers and practice mentors Aim of paper answered and evidenced	Study conducted in one Trust when the model was implemented as a response to the short lead-in time of the HVIP	Peripatetic model well accepted. Development of guidelines and training to support the PT/mentor partnership clarifies roles and levels of assessment Progression pathways for newly qualified SCPHNs called for

Author/date/journal	Title of study	Study type	Main findings	Strengths	Limitations	Implications for practice
			PTs uneasy relying on mentor assessment			
Devlin, A., Adams, K., Hall, L., & Watts, P. (2014) HEE.	Educating PTs and specialist practice mentors for their new role: Ensuring high quality practice learning. Final report from task and finish group on HV practice education	Qualitative survey of over 700 PTs, mentors, clinical managers and HV students	The traditional one-to-one PT student model has been replaced by different models of practice teaching, supervision and support	Large scale national study Presents findings from the task and finish group established by Health Education England in Feb 2014 Aim of the report was answered and evidenced in the paper	The expectations associated with emerging roles and the educational preparation and support provided for the roles are unclear.	HEIs should review PT and specialist mentor programmes to reflect the requirements of the expanded and enhanced roles Specialist practice mentors should be offered a programme of preparation and selected because of their enthusiasm
Devlin, A., & Mitcheson, J. (2013) Journal of Health Visiting, 1(10), 574-581	An evaluation of three models of practice teaching in health visiting in NHS-East of England, DH funded report	Mixed methodology practice portfolio audit (n=34) and survey of recently qualified HVs (n=39) Phase 2 data collected from four focus groups (34 participants)	Irrespective of the model, PTs conform to NMC standards Regardless of the model, students felt confident to undertake their role Disparities were not related to the practice education model in operation	Peer reviewed Concerned SCPHN-HV Evaluates three models of practice-based teaching across East of England from a multi-stakeholder perspective Aim of the paper answered and evidenced	Study was conducted only in the East of England, which has recruitment difficulties	Practice placement changes are considered to be highly disruptive to learning and progression Calls for research which considers the views of PTs and mentors, and the mechanisms they employ to manage the opportunities and challenges of their role
Haydock, D., & Evers, J. (2014)	Enhancing PTs' knowledge and skills using collaborative action learning sets (ALS).	Mixed method pre- and post-intervention survey. Sample of 8 trainee PTs and 3	PTs felt ALS enhanced their knowledge and skills Skills were role modelled to students to	Peer reviewed Project awarded HEA Teaching Development grant	Small scale study in one HEI Small sample, therefore may	ALS improve the educational development of trainee and experienced PTs when used as part of PT development

Author/date/journal	Title of study	Study type	Main findings	Strengths	Limitations	Implications for practice
Community Practitioner, 87(6), 20–24		focus groups of trainee PTs, practice education facilitators and students	guide reflection and knowledge acquisition	Presented at the NET conference 2013 Aim of the research was answered and evidenced in the paper	not be transferable.	Impact of ALS on the trainee PT role and associated students was beneficial to all parties
Haydock, D., Mannix, J., & Gidman, J. (2011) Community Practitioner, May 84(5), 21-25	CPTs perceptions of their role satisfaction and levels of professional burnout	UK mixed method study exploring perceived role satisfaction and professional burnout among SCPHN and SPC CPTs	CPTs were satisfied with support from HEIs, but dissatisfied with support received from Trusts. CPTs were exhibiting moderate levels of emotional exhaustion	Peer reviewed Concerns SCPHN PTs Validated data collection tool SPSS Aim of research was answered and evidenced in the paper	Small scale study 23 attending one HEI, therefore may not be transferable	Trusts need to implement reduced clinical caseloads and supervision specific to mentorship Employers and HEIs need to understand the causes and signs of burnout
Lindley, P., Sayer, L., & Thurtle, V. (2011) Perspectives in Public Health, 131(1), 32-37	Current educational challenges for SCPHN following a HV pathway and the consequences of these challenges for public health	Discussion paper drawing on professional and educational literatures	Identified issues affecting education of SCPHN Difficulties in recruitment, numbers of PTs, and gap between expected and actual practice roles for HVs	Peer reviewed Concerns SCPHN PTs Summarises issues affecting SCPHN education, delivery of HV services in UK Aim of paper was answered and evidenced in the paper	Setting UK Pertaining to SCPHN-HV only	Discusses factors concerning HV education Makes recommendations for action by HEIs
Morton, S. (2013) Community Practitioner, 86(8), 32-35	What support do HV mentors need?	Qualitative study. Purposive sample of 8	Mentors felt 'powerless' as the role was imposed upon them	Peer reviewed One of the first papers to explore the role of the mentor of SCPHN-HV students and impact of HVIP	Setting UK Small sample size 15, therefore may not be transferable	There is shift in responsibility as mentors now directly manage SCPHN students and need support to manage the pressure of the dual role

Author/date/journal	Title of study	Study type	Main findings	Strengths	Limitations	Implications for practice
			They felt ill prepared, unsupported and compromised	Aim of the research was answered and evidenced in the paper		Calls for standards for the professional development of mentors
Newland, R. (2009) Unite the Union/ CPHVA, London	Investigating the role and professional development of the PT	Survey completed by 79 PTs	40% of PTs spent hours undertaking further roles such as team leader, preceptor and manager, in addition to caseload responsibilities and their student	Peer reviewed Concerned SCPHN PTs Relatively large survey Aim of the research was answered and evidenced in the paper	Setting UK only	Survey identified there was a gap in the literature in relation to how practice teachers viewed themselves, and how their role was perceived by students and managers
Poulton, B., Lyons, A., & O'Callaghan, A. (2008) Community Practitioner, 81, 9	A comparative study of self-perceived public health competencies: Practice teachers and qualifying SCPHN	UK quantitative study comparing self-perceived public health competencies of qualifying SCPHN students with those of PTS	PTs are more confident than students at leading and managing public health Qualifying students self-rated higher than PTs on principles and practice of public health	Peer reviewed journal Concerns SCPHN PTs Validated data collection tool SPSS Aim of research was answered and evidenced in the paper	Small sample size of 35, therefore findings may not be transferable	Triennial review of PTs should include educational and public health skills CPD should be supported and funded and role of PT recognised and remunerated
Sayer, L. (2011) Nurse Education Today, 31, 558-563	Strategies used by experienced versus novice practice teachers to enact their role with community nurse students	UK qualitative study. Constructivist grounded theory. Lightly structured interview approach	Relationships and nurturance to be of central importance Novice PTs identified students as experiencing major difficulties more than experienced PTs.	Peer reviewed PhD study Concerned SCPHN PTs. Aim of research was answered and evidenced in paper	Sample taken from one HEI consisting of 30 PTs	PTs learn to enact their role within a socio-cultural context. This takes three years to establish Implications for novice PTs and the students they mentor and the associated Trust and HEI

Author/date/journal	Title of study	Study type	Main findings	Strengths	Limitations	Implications for practice
Whittaker, K., Grigulis, A., Hughes, J., Cowley, S., Morrow, E., Nicholson, C., Malone, M. & Maben, J. (2013) National Nursing Research Unit, London	Start and stay: The recruitment and retention of HVs	Literature review on NHS and other workforces Qualitative empirical study 54 participants in total	Analysis of recruitment and retention issues specific to HV Key areas: the nature of work; organisation of recruitment and training; being valued and respected	Commissioned by the DH, and undertaken by the National Nursing Research Unit (NNRU) to inform and support the HVIP Aim of the paper was answered and evidenced in the paper	Did not include service users. However, the report acknowledges this as a limitation Did not explore why HVs leave the profession	Called for research that examines the quality of practice learning for students including the contribution of the PT role (in comparison with that of the mentor), and the impact of 'long-arm' models on student learning

Further non-research papers deemed to be particularly pertinent to the research were also reviewed:[7]

Gillespie & McFetridge (2006)	Critical review of evidence related to the role of the nurse teacher
Harries (2011)	Discussion paper on PT student ratios
Naughton (2013)	Discussion on PT numbers
Sprinks (2013)	Discussion paper on PT/mentor burnout
Greening & Haydock (2014)	Evaluation of a leadership programme for Band 6 health visitors
Bayliss-Pratt (2015)	Discussion paper concerning PT and mentor role

The emergent themes derived from the literature included the multi-faceted nature of the PT/mentor role; the additional demands resulting from the complex duality of caseload manager and educator roles; support structures for PTs, mentors and students; and resource implications. These themes are considered in relation to practice education before and during the HVIP, including how the HVIP has impacted upon models of education and the identity of mentors, PTs and students. These themes form the basis of the ensuing critical appraisal.

Emergent themes from SCPHN-HV practice education literature

Two dominant themes from the literature were elicited:

1. The multi-faceted nature of the dual role of caseload manager and educator
2. The perceived demands felt by the PT/mentor.

Two subordinate themes were identified:

a. Resource implications
b. Associated support structures.

Figure 1 illustrates the dominant and subordinate themes emerging from the literature.

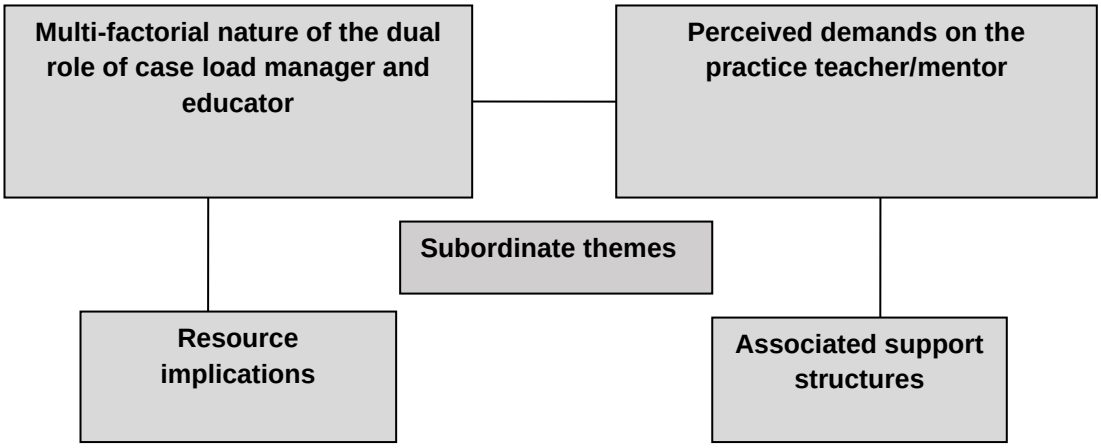
[7] Researcher publications cited in this literature review section:

Haydock, D., Mannix, J., & Gidman, J. (2011). Community Practice Teacher's perceptions of their role satisfaction and levels of professional burnout. *Community Practitioner*, 84(5), 19-23.

Greening, K., & Haydock, D. (2014). Delivering a health visiting leadership programme. *Community Practitioner,* 87(3), 35-37.

Haydock, D., & Evers, J. (2014). Enhancing practice teachers' knowledge and skills using collaborative action learning sets. *Community Practitioner*, 87(6), 20-24.

Figure 1: Emergent themes



Critical appraisal

The multi-faceted nature of the dual role of caseload manager and PT/mentor

SCPHN programmes are developed with a 50/50 practice/academic emphasis (NMC, 2008). Within a limited timeframe of 52 weeks, the PT engages in a process of education concerned with leadership and development of specialist competencies (Carr & Gidman, 2012; Haydock et al., 2011; NMC, 2004a). The PT is charged with supporting and supervising practice learning, with mentorship facilitating the development of competent practice, aided by supportive longer-term mentor–mentee relationships (Van Eps, Cooke, Creedy, & Walker, 2006). The NMC 2008 standards required decisions about whether a student had achieved the required standards of proficiency for entry to the register, and stated these must be made by a sign-off mentor (NMC, 2008, 2010b). The literature which pre-dates the 2+1 programme emphasises the difficulties associated with the PT role as SCPHN students are seen as requiring considerable support in order to develop leadership and higher cognitive skills (Carr & Gidman, 2012). Previous government reforms are reported to have affected recruitment and practice education with many HV students entering training with minimal nursing experience, requiring increased support from PTs and mentors (Haydock et al., 2011). Students are reported as having high expectations of the support they require from PTs, with PTs playing a pivotal role in both learning and maintaining student enthusiasm (Whittaker et al., 2013).

In addition to facilitating learning for potentially inexperienced students, the PT may also be supporting a number of students and mentors simultaneously (DH, 2011a). Sayer's (2011) study explored what it is like to be a PT, identifying that the primary

focus is on identity transformation. The findings suggest that inexperienced PTs require time to develop skills, learning to enact their role within a socio-cultural context by drawing upon a transformational approach to learning; this typically takes three years to master (Sayer, 2011). This is pertinent as inexperienced PTs are much more likely to identify students as experiencing problems as they are learning to cope with competing demands (Haydock et al., 2011; Sayer, 2011). The literature conveys a complex picture of the multi-faceted role of clinician and educator. PTs are spending 40% of their time assuming identities other than that of PT, undertaking additional roles alongside caseload and educational responsibilities such as team leader, supervisor and preceptor (Newland, 2009). The literature suggests that SCPHN-HV education is complex, and emerging models of mentorship and increasing numbers of novice PT/mentors and inexperienced students appear to add to the complexity of health visitor practice education post-HVIP.

The perceived demands on the PT and mentor

The literature highlights the heavy demands placed on PTs and mentors when carrying out their dual role. These include issues of time management, and the increased accountability and responsibility associated with practice education (Carr & Gidman, 2012; Deave et al., 2017; Haydock et al., 2011; Morton, 2013). PTs highlight difficulties in time management, resulting in a poorer work-life balance and the potential for emotional exhaustion (Haydock et al., 2011). PTs are dissatisfied with managing competing responsibilities including heavy caseloads and the provision of day-to-day support and supervision for one or more students, and students observe PTs trying to manage increasingly competing demands (K. Adams, 2013). Devlin et al. (2014) suggest that models of practice teaching have moved considerably from the traditional one-to-one model and are variable across England. The Devlin et al. (2014) nationwide survey of over 700 practice teachers, mentors, clinical managers and health visiting students reported the findings from the Task and Finish Group on Health Visitor Practice Education established by Health Education England in February 2014. The report presents findings related to models and experience of learning in practice, and reviewed the evidence-base related to effective learning. Overall, the report indicated a generally positive response to the evolving models of practice education; however, PTs and mentors were reported as continuing to struggle with workload/time management issues and meeting student and clinical requirements, alongside additional pressures from the number of students requiring support (Devlin et al., 2014; Morton, 2013). Bayliss-Pratt (2015) suggests there is a lack of clarity with regards to the expectations placed upon practice teachers

and mentors and the preparation provided for the roles. Deave et al. (2017) in their evaluation of new models of practice education support these findings, calling for recommendations to develop guidelines to support the PT/mentor partnership. The study by Deave et al. (2017) considered the implementation of a peripatetic assessment model from the perspective of students, PTs, mentors and managers, concluding that in general the model was accepted. However, some students questioned the PTs' ability to assess them adequately as the PT had not worked with them directly, and both PTs and mentors struggled with the challenges of caseload and mentorship roles. The research studies critiqued are in the main small scale and related to one geographical area; however, the Devlin et al. (2014) nationwide survey supports the findings of the smaller studies with regards to expectations and lack of preparation for the role of PT. As experienced leaders of practice education, PTs are required to be up to date with contemporary practice and public health policy (NMC, 2008), and Deave et al. (2017) did report that mentors felt their new role had upskilled them. However, the literature suggests this is not always the case with some feeling less competent in key public health skills than their students (Poulton et al., 2008). This is of concern as PTs and mentors are required to integrate the knowledge and skills attained in the classroom into real world public health practice, which is problematic if they do not identify themselves as public health practitioners.

PTs express the felt responsibility of the lone assessor role in relation to signing-off students for NMC registration (Carr & Gidman, 2012; Haydock & Evers, 2014; Haydock et al., 2011). Since the HVIP, long arm mentorship models have resulted in PTs being responsible for sign-off to the NMC of numerous students without the day-to-day contact associated with the one-to-one model (Deave et al., 2017; Devlin et al., 2014). To add to the complexity of the long arm model, some PTs are supporting mentors and students across wide geographical areas. The increased responsibility is pertinent as trainee and novice PTs typically take three years to learn their role, and during this time they have difficulty accessing support and are more likely to identify students as experiencing major difficulties than experienced PTs. This has implications for novice PTs, the students they mentor, and the associated Trust and HEI (Sayer, 2011).

The literature points to protected time, reduced caseloads, and increased peer supervision and support as the main ways to reduce the demands felt by PT/mentors and increase their role satisfaction and sense of identity (Carr & Gidman, 2012; Deave et al., 2017; Haydock & Evers, 2014; Haydock et al., 2011). The papers critiqued concern small sample sizes, the majority in one geographical area; however, the

papers cover from 2008 through to 2017, the period pre-, during and post- the HVIP, and present findings consistent with each other: issues of preparation and support for the role, the pressure of increased responsibility, and lack of protected time.

Associated support structures

The literature depicts PTs and SCPHN mentors as dissatisfied with the lack of support and recognition received from colleagues and employing organisations. Organisations are perceived as not valuing or understanding the complexity of the educational role (K. Adams, 2013; Devlin et al., 2014). The literature suggests that prior to the HVIP, PTs were satisfied with the support they received from HEIs (Carr & Gidman, 2012; Haydock et al., 2011); however, the mentors in the Deave et al. (2017) study reported feeling less supported by the HEI, and Sayer (2011) also reported variances in novice and experienced PTs and mentors seeking support from HEIs and Trust management. The literature suggests that additional support is required for novice PTs to enable them to utilise the strategies employed by experienced PTs when supporting students (Sayer, 2011). K. Adams (2013) points to the ambiguity of the PT role, suggesting that a clearer professional identity is required so that educational preparation can be developed specifically to meet the needs of PTs.

The literature pertaining to SCPHN mentors presents an overarching theme of powerlessness. Mentors describe having the identity of SCPHN mentor imposed in addition to caseload responsibilities, stating they feel ill prepared for the role and poorly supported by managers (Devlin et al., 2014; Morton, 2013). Research by Haydock et al. (2011) called for support that acknowledged the pressure of the dual role of caseload manager and educator. Morton (2013) also calls for support that acknowledges the pressure of their dual role, as mentors have taken on the additional educational role previously undertaken by PTs. The types of support include access to CPD and face-to-face annual updates for mentors facilitated by a PT and the relevant HEI (Morton, 2013). In keeping with previous research concerning PTs, the work-life balance for mentors is cited as problematic, as they struggle to cope with client care, student education and family responsibilities. Mentors reduce their psychological discomfort by prioritising caseloads and working overtime (Morton, 2013). Critical evaluation of the research reveals only small numbers of research studies which report students' views; those that do, depict students as generally happy with their placement experience, with PTs and mentors reported to be knowledgeable, motivated and friendly (Deave et al., 2017; Devlin et al., 2014;

Haydock & Evers, 2014). Although students felt placements were well organised, mentor/PT protected time was cited as problematic. Devlin et al. (2014) found that long arm arrangements were made difficult by geographical distance, resulting in mentors requesting additional support from managers and universities. In keeping with previous PT research, mentors reported feeling concerned about the quality of the practice education they provide (Morton, 2013).

Resource implications

As the role of PT/mentor is operationalised differently across organisations, no model of practice education emerges as dominant; the resources available to support the PT role also vary (K. Adams, 2013). The literature, however, indicates that most PTs and mentors do not have reduced caseloads and consequently are dissatisfied with managing competing responsibilities. Devlin et al. (2014) highlighted that practice placements are perceived as excellent when they work effectively, though they report inconsistencies across areas. PTs were concerned about staffing levels in general and the availability of other team members to support the student placement, particularly at its commencement. The absence of additional staff to cover backfill is also highlighted; this is required in order for the PT to support student mentorship and reflection, attend HEI mentor updates and undertake academic modules (Carr & Gidman, 2012; Haydock et al., 2011). Although HEI resources were positively reviewed, the timing of updates and courses caused problems; week long modules would be easier to plan for as opposed to once weekly attendance (Carr & Gidman, 2012). Resources such as peer supervision and educational and clinical supervision were highlighted as pivotal to the development and identity of the PT role (Carr & Gidman, 2012; Haydock et al., 2011). Study days specifically related to public health were emphasised as a potential resource, and the triennial review was an opportunity to discuss educational and contemporary public health practice (Poulton et al., 2008).

The literature depicts the PT role as a complex and multi-faceted responsibility (Lindley et al., 2011), with SCPHN students requiring considerable support from their PT in order to develop leadership and cognitive skills (Carr & Gidman, 2012; Haydock et al., 2011). This has to be achieved within a limited timeframe set against a backdrop of reduced staffing levels and finite resources. Recent government and nurse education reforms have affected educational practice as additional numbers of pre-registration student nurses also require community placements alongside increased numbers of SCPHN students. The literature suggests that experienced PTs are dissatisfied with their new identity of long arm mentor, as they are increasingly asked

to supervise numerous students and trainee PTs with no reduction in clinical responsibility (Harries, 2011; Morton, 2013). Additionally, novice and trainee PTs cannot always access support when they are experiencing difficulties (Sayer, 2011); this has implications for the student, the trainee PT and service requirements. According to NMC (2011) and Centre for Workforce Intelligence (2012), the demographic profile of the profession suggests that many experienced SCPHN will retire in the near future. This is likely to result in a situation where there are more newly qualified practitioners in the workforce than experienced practitioners, making effective practice education ever more pivotal in the preparation of future health visitors. New long arm models of practice education are seen as challenging, impacting on the practice area with confusion over the numbers of students assigned to PTs. Variations across the country have raised concerns with regards to how the NMC (2008, 2011) standards are being applied (Harries, 2011; Naughton, 2013).

Increasing demands and relentless government reforms make the dual clinical and educational role of PTs complex, causing challenges to facilitation and assessment of students in practice (Carr & Gidman, 2012; Gillespie & McFetridge, 2006; Haydock & Evers, 2014; Lindley et al., 2011). Even prior to the HVIP, there appeared to be an association between high workload demands, role dissatisfaction and loss of professional identity (Adams, 2013; Carr & Gidman, 2012; Haydock et al., 2011). PTs were expressing difficulty when engaged in a one-to-one model of education and some were experiencing moderate degrees of emotional exhaustion (Haydock et al., 2011). The research evidenced that the demands had implications for work-life balance as PTs reported being unable to complete all of their duties within work time (Haydock et al., 2011; Lindley et al., 2011). Protected time, reduced caseloads, and increased peer supervision and support are approaches to reduce the demands felt by PTs and increase role satisfaction; however, according to the literature these do not happen (Carr & Gidman, 2012; Haydock et al., 2011). The HVIP has brought additional pressures as PTs and mentors continue to struggle with workload pressure alongside supporting more than one student at a time; this situation is complicated further by geographical distances in many instances (Deave et al., 2017; Devlin et al., 2014; Morton, 2013; Sprinks, 2013).

Increased student numbers resulted in PTs being required to develop flexible models of education (DH, 2012). Strategies such as action learning sets (Revens, 1982) are employed in recognition that the role is complex and demanding (Haydock & Evers, 2014). Such strategies are seen as necessary to meet the increased demand for student placements, and to take into account the changing identity and nature of

SCPHN students who are entering the profession with limited experience (DH, 2012). Some Trusts are introducing PT led learning sets where students and PTs discuss learning needs, in addition to LAM (Deave et al., 2017). Despite the acknowledged variance in student experience, the PTs/mentors are still expected to develop students' specialist public health, leadership and problem solving skills within a limited timeframe (DH, 2012). This relies heavily on the PTs or mentors maintaining credibility as public health practitioners, identifying themselves as experts and leaders in public health (Poulton et al., 2008). Devlin et al. (2014) discuss the attributes of good leadership as pivotal for the creation and maintenance of positive learning environments. However, it cannot be assumed that all PTs and mentors identify themselves as leaders in practice. The Greening and Haydock (2014) study reported that health visitors lack confidence in their leadership capability, recommending leadership programmes aimed at specifically developing the leadership knowledge of health visitors.

Conclusion and relevance to proposed research

The quality of placements is of significant importance to educationalists, service users, providers, commissioners and students (Deave et al., 2017; Devlin et al., 2014; Haydock et al., 2011). As the demographic profile of the profession changes with 50% of the workforce being newly qualified by 2015 (Centre for Workforce Intelligence, 2012; NMC, 2011), practice placements will be ever more crucial as newly qualified HVs will have fewer experienced colleagues to support them. Critical appraisal has uncovered a number of discursive and research papers concerning SCPHN practice education. The literature review of 13 research studies summarises current research trends and issues. The majority of the research pertaining to SCPHN practice education (all of which pertains to the UK) uses small sample sizes. However, the research and grey literature provide an overview of primary evidence. There is an identified paucity of research exploring how PTs, mentors and HV students experience practice learning placements and there appear to be no studies pertaining to 2+1 HV students. This is an identified gap in the body of knowledge concerning HV practice education and an aspect left unexplored, so their experiences are unknown. Whilst recent studies have highlighted the changing nature of health visitor practice placements, there also appears to be a methodological gap: there are no in-depth qualitative studies focusing on PTs, mentors and students' experience of SCPHN practice education, and in particular no IPA studies were uncovered. Specifically, the impact of the HVIP (DH, 2011a) on models of education and the experiences of PTs, mentors and students is relatively unexplored. This is a limitation acknowledged by

previous researchers who call for research to examine how the PT/mentor role is operationalised, covering opportunities and challenges of the role and the quality of practice learning, and including long arm models (Devlin et al., 2014; Devlin & Mitcheson, 2013; Whittaker et al., 2013). A further philosophical gap in the literature concerns the application of a conceptual framework. No previous studies appear to consider HV practice education through a conceptual framework. Pierre Bourdieu's theory of practice therefore acts as a unique lens to enrich understanding of the interplay between participants and structures, making a distinctive contribution to the body of knowledge concerning practice education.

Aim of the research

This study aims to explore 2+1 student health visitor, practice teacher and mentor experiences of practice placements and emerging practice education experiences within the context of the Health Visitor Implementation Plan, through the lens of Bourdieu's theory of practice.

Research questions

Specifically, the research will address the following questions:

- How do 2+1 student HVs perceive and interpret their experiences when placed with mentors and PTs?
- How do PTs and mentors perceive and interpret their experiences when facilitating learning in placements for 2+1 student HVs?
- To what extent can Bourdieu's key theoretical constructs – habitus, field and cultural capital – be used to locate and understand the participant narratives?

Chapter conclusion

This chapter has presented the literature review, including the search strategy used, a critical appraisal of the literature and the themes which emerge from it. Conclusions have been drawn from the literature and discussed in relation to the study aim and questions. The discrete area the thesis focuses on has been presented, including the overall aim of the study and the research questions the study will address.

Chapter 3: Research methodology and methods, conceptual and theoretical frameworks

Having considered the historical origins of HV practice education within the wider policy context of nurse education, this next chapter will present the rationale for the selected methodology and method and introduce the conceptual and theoretical framework for the study. An overview of Bourdieu's theory of practice is given, and research paradigms are debated in relation to the theoretical framework of phenomenology and interpretivism. Epistemology and ontology are explored, as is the relation of these key concepts to the research process, including the formulation of the research aim and questions and the choice of methodology. The theoretical origins of phenomenology and interpretivism are considered, concluding in a critical evaluation of interpretive phenomenological analysis (IPA) (J. A. Smith, Harré, & Van Langenhove, 1995; J. A. Smith, 1996). A coherent argument defends the application of interpretive phenomenology and IPA as an appropriate underpinning philosophy and analytical approach to explore SCPHN-HV practice education whilst considering issues of researcher positionality. The research method for the study, including semi-structured conversational interviews, sampling procedures, data analysis procedures and timescales, is introduced alongside consideration of ethical issues including ethical approval, protection from harm, and issues of power and coercion. Consent, anonymity and data protection are discussed, and the concepts of validity, rigour and reflexivity in interpretivist research are considered in relation to Yardley's (2008) evaluative criteria and Bourdieu's reflexive epistemology.

The application of a conceptual framework

A literature review in isolation can be interpreted as a purely descriptive exercise, presenting previous research and theoretical work undertaken in a subject area (Maxwell, 2005). The application of a conceptual framework aids the critical exploration of existing and new knowledge contributions, framing the issues and acting as a tentative theory of the phenomenon under investigation (Maxwell, 2005). Once the literature had been critically appraised, the emergent themes concerning the multi-faceted nature of the PT/mentor role could be viewed from a number of theorists' perspectives. Bourdieu's theory of practice (Bourdieu, 1977) was considered particularly useful to the framing and analysis of the research findings, as it enabled me to consider practice placements as dynamic social spaces, including the interactions between the participants or agents and the structure of the field. Bourdieu's emphasis on practice and his consideration of neoliberalist policy as a way to understand how social policy impacts upon professional practice, including

educational placements, was deemed particularly congruent with the research aim. As indicated in the previous chapter, there was also a philosophical gap in the literature as there appear to be no previous studies which consider current HV practice education through the lens of Bourdieu's theory of practice. This study could therefore enhance understanding of how educators and students experience SCPHN practice and policy changes. Habitus, field and cultural capital, the theoretical constructs referred to as 'thinking tools', can be drawn upon to make sense of and interpret the data emerging from this study, providing an alternative perspective to frame the issues. Bourdieu developed his theory of practice and the key concepts of habitus, cultural capital and field in the 1960s: it considers that practice results from an individual's habitus, their past experience, education, and upbringing, and the individual's position within the field. This position is considered in terms of capital in the game of play.

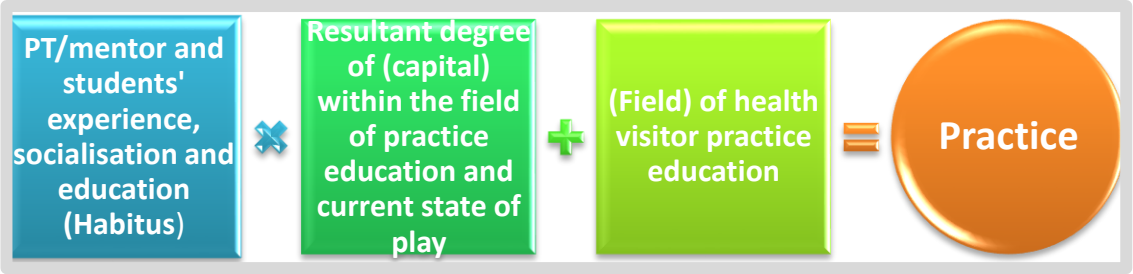
Bourdieu's theory of practice

Bourdieu is regarded as an eminent 20th century social theorist and philosopher. Primarily, his work concerns anthropology, education and culture; however, it has been applied to a wide range of disciplines. Bourdieu considered neoliberalism to be an assault on every sphere of life, and much of his later work was concerned with exploring the social and cultural consequences of neoliberalism, including the privatisation of educational organisations (Brown & Szeman, 2000). Bourdieu's work therefore has resonance with the issues discussed in the previous chapter with regard to the impact of policy on the health and social care and higher education arenas. Bourdieu considers practices to be the outcome of the unconscious relationship between habitus and field, as habitus alone does not result in practice; rather, the relations between habitus, culture and field are significant (Maton, 2008). Bourdieu illustrates this interplay with the following equation:

[(Habitus) (Capital)] + Field = Practice (Bourdieu, 1984, p.101)

In terms of this study, Figure 2 illustrates how I have borrowed Bourdieu's equation and adapted it to demonstrate the relationship between the participants' habitus, degree of capital and the field of health visiting practice education itself, all of which equal practice.

Figure 2: Bourdieu's key concepts applied to this study



In subsequent chapters Bourdieu's inter-related theoretical constructs will be drawn upon in detail to frame the analysis and discussion. However, an overview of each concept will be given next in order to introduce Bourdieu's epistemology. Bourdieu considers the interrelation between the three thinking tools to be crucial, as the elements make reference to each other.

Habitus

Bourdieu sought to join the concept of structuralism, where structure in the form of rules determines individual thoughts and actions, and the concept of agency which suggests that individuals are free thinkers able to choose different options and alternatives. Bourdieu considered structuralism to discount agency, whilst agency discounts larger influencing structures which impact on and contain agency. Bourdieu's theory of practice is an attempt to bring dualistic views of objective social structure and subjective personal experience together (Maton, 2008). Bourdieu uses the term habitus as a way of viewing the social world, considering habitus to entertain with the social world that has produced it, linking the individual and the social world, describing how the inner and outer are both internalised (Bouveresse, 1999). Experience, although unique to individuals, is shaped in terms of social forces and structure by others who share similar characteristics such as class, gender, occupation and nationality; this embodied social structure gives individuals a similar societal position and capital (Nash, 1990). The term habitus is therefore used by Bourdieu to link social structure, personal experience and agency to explain how individuals create and recreate societal structure. Bourdieu defines habitus as: "*a structuring structure, which organises practices and the perception of practices*" (Bourdieu, 1984, p.170).

Habitus is structured by past and present circumstance, acquired during primary and secondary socialisation in the world (Bonnewitz, 2005). Primary socialisation refers to the way an individual was raised, which is influenced by parental position within a

social space, their social position. Social position is seen to be connected to the adoption of certain lifestyles, tastes and cultures such as thoughts, hobbies, sporting activity, choice of foods, clothes and view of the world, all of which reflect an individual's position in society, referred to by Bourdieu (1984) as class habitus. Secondary habitus is primarily concerned with experiences and socialisation acquired in education, such as school, college and university; combined with other experiences, this builds upon the foundation of primary habitus. Primary habitus is accumulated over formative years and is therefore not always conscious but internalised as second nature, referred to by Bourdieu (1990) as "embodied history". As a result, primary habitus is influential on secondary habitus, creating a unified habitus; this creates a set of dispositions that in turn produce perceptions and practices which are structuring as habitus is reinforced and modified. This shapes present and future practice, locating an individual's position within a field (Maton, 2008). Habitus and field are therefore relational, each shaping the other as relations evolve; this is central to social reproduction and change. Practices are a result of the unconscious relationship between habitus and field as behaviour becomes so internalised it appears automatic, being referred to as a 'permanent disposition': *"habitus is that which one has acquired but which has become durably incorporated in the body in the form of permanent dispositions"* (Bourdieu, 1993, p.86).

Bourdieu does not consider individuals to be predispositioned, however; rather, he asks us to consider objective structures such as access to education and the relationship between structure and practice, so that we can explore how these relationships are established and how habitus might constrain. Bourdieu interprets habitus as fluid, not determined as experiences reinforce or change structure. Key to this notion is reflexivity as awareness of personal habitus aids relative objectivity, whilst also considering the concept of a 'logic of practice' which results from lasting exposure to similar conditions to those the agents finds themselves in (Bouveresse, 1999). This can be seen as crucial for the researcher and will be explored later in the thesis. Habitus can therefore be viewed as the subjective element of practice; however, it is also structured and structuring, and can be used to explain how practice can be determined and acting (Grenfell, 2012). Habitus, including knowledge accumulated through primary and secondary socialisation, sets the terms of engagement and rules, limiting practices and strategies. Habitus subsequently produces modes of behaviour which are actions guided by a 'feel for the game', yet they are based on instinctive behaviour rather than reason. This can be likened to

tacit knowledge (Moule, Aveyard, & Goodman, 2016) whereby individuals tacitly recognise and act within the rules of the specific field.

Field

Bourdieu considers the space which we inhabit as social agents in terms of a field, occupied by individuals or institutions where interactions and social exchanges take place (Walther, 2014). This social world is constituted of many large fields such as education, art, science, religion, medicine and employment, and within these fields there operate smaller sub-fields which follow the overall logic of the large field. Crucially, each field is autonomous and has its own unique set of internal rules, and thereby the field represents the structural element of Bourdieu's theory of practice (Walther, 2014). Social fields change over time, and so the history of the development of the field should be examined. Thomson (2012) suggests this furthers the understanding of the field in its current form, including how the agents experience the changing fields' shape and orientation. Each field, such as health visitor practice education as discussed earlier in this chapter, has a history where practice is produced and reproduced as part of an ongoing construction. Although the field of health visitor practice education can be viewed as autonomous, this is only relatively valid as it is embedded within the wider fields of nurse education and higher education and, as the literature review has shown, is influenced by the political and economic fields (Walther, 2014). Bourdieu considers neoliberalist ideas to be a particular danger to the autonomy of various cultural fields, as the adoption of market forces erodes recognition affecting cultural and intellectual production (Brown & Szeman, 2000).

Bourdieu uses the analogy of a football game to depict how a social field is constructed and enacted. A football game consists of players who all have a determined position, predicated on criteria including skills, personal history and experience, social connections and their usefulness to the team. The game has its own set of rules which are rationalised, understood and internalised by the players, giving the social space a logic of practice (Brown & Szeman, 2000). This ensures the players know what is expected of them and of each other, so they behave in accordance with the rules which are normalised and second nature. Each field, according to Bourdieu, has a boundary; this separates and distinguishes fields, protecting those within. The boundaries are where the effect of the field dissipates and another field begins (Walther, 2014). On the inside, power relations result in dominant agents and hierarchies, which in turn determine the scope of individual practice and social mobility (Thomson, 2012). Educational fields such as school or

university also impact upon the agents' position in society and in the economic field (Grenfell, 2012). Fields are therefore changeable and competitive places where agents vie for position; this is achieved through maximising accumulated capital, whilst conforming to the rules of the field (Walther, 2014). The field itself is not a fixed structure; rather, there is the possibility of movement and change, allowing individuals to assert individual agency (Thomson, 2012). However, whilst Bourdieu considers that an agent's position within the social field is determined to an extent by individual agency, it is primarily determined by capital which is related to habitus and field.

Capital

Bourdieu (1984) considers social life to be based upon resources accumulated over time, which he terms capital: these are an element of the structuring process of habitus. Bourdieu divides capital into four categories: economic, cultural, social and symbolic, all of which are used as instruments to achieve dominance within the field. Economic capital is concerned with wealth and assets such as property and income; cultural capital pertains to an individual's knowledge and experience which gives access to culture and connections; social capital is the network around the individual which begets societal recognition; and symbolic capital is the resources and respect given to the individual, denoting the individual's value within a field (Walther, 2014). Bourdieu considers culture as both structural and functionalist: structural culture concerns the shared consensus within the field acting as a mechanism for communication and knowledge transmission, while functionalist culture is created around human knowledge which is the product of the social infrastructure (Grenfell, 2012). Bourdieu asserts that social, cultural, and symbolic capital can be converted into economic capital; although cultural and economic capital are beneficial, economic capital carries more status as the more economic capital the individual has, the greater their position within the field.

In order to gain cultural capital, individuals must be familiar with the dominant culture in the field, the rules of the game. With this comes the attainment of cultural capital which bestows distinction on the individual, material advantage and often symbolic capital. Bourdieu argues that this results in a process of social reproduction where the established order of the field is protected and replicated through a process of cultural reproduction (Jenkins, 2002). Bourdieu therefore considers culture from a structural and functionalist perspective, observing structures of the field including organisations, practice and thought to uncover the logic of practice within the field (Grenfell, 2012). Bourdieu concluded cultural and economic capital to be strongly

associated with education and class status, as educated middle class parents have previously navigated educational systems and as a result know the system, and also hold the economic capital to access the same for their children (Bourdieu, 1994). Bourdieu distinguishes between the concepts of economic capital and symbolic capital, and the differences between the two are viewed as crucial. Bourdieu considers cultural capital as part of a wider exchange where assets such as education are transformed within the field, giving some a greater degree of capital and social advantage (Moore, 2012). As a sociologist, Bourdieu was concerned with social differentiation in the form of class; however, his theories can also be used to consider differentiation within fields and how this affects the individuals within the field (Grenfell, 2012). Within this thesis, Bourdieu's theory of practice will be drawn upon to consider the way students and educators experienced practice education.

Further operational definitions discussed in this thesis

Doxa

The term doxa is derived from the Greek, meaning common belief. Within a field there are taken-for-granted assumptions and nuanced beliefs, a shared set of rules. Bourdieu uses doxa to convey a sense of place and internalisation of the rules which is deep rooted, resulting in shared habitus. When players are dominant, comfortable and embedded in the field, habitus becomes part of the doxa of practice, comparable to being 'a fish in water' (Bourdieu & Wacquant, 1992).

Hysteresis

Bourdieu also considers when an individual's habitus does not fit with the doxa of the field as can occur in periods of crisis or transition. This dissonance between habitus and field results in a feeling of being like 'a fish out of water'. Bourdieu refers to this concept as a state of hysteresis (Bourdieu, 1977).

Theoretical framework

As critically appraised in the previous chapter, the HVIP (DH, 2011a) has impacted significantly upon practice placements. The professional identity of the HV is seen to be shaped by political manifesto with the dominant discourse in health visiting changing to mirror the social and political conditions of the time. Garratt (2013) suggests that all interpretation of data is influenced by social and political contexts, and this in turn affects both the way health visiting is viewed and the acknowledged regime of truth. Bourdieu's extensive work on fields explores the significance of the historical context on social space, including how prior understanding about the area

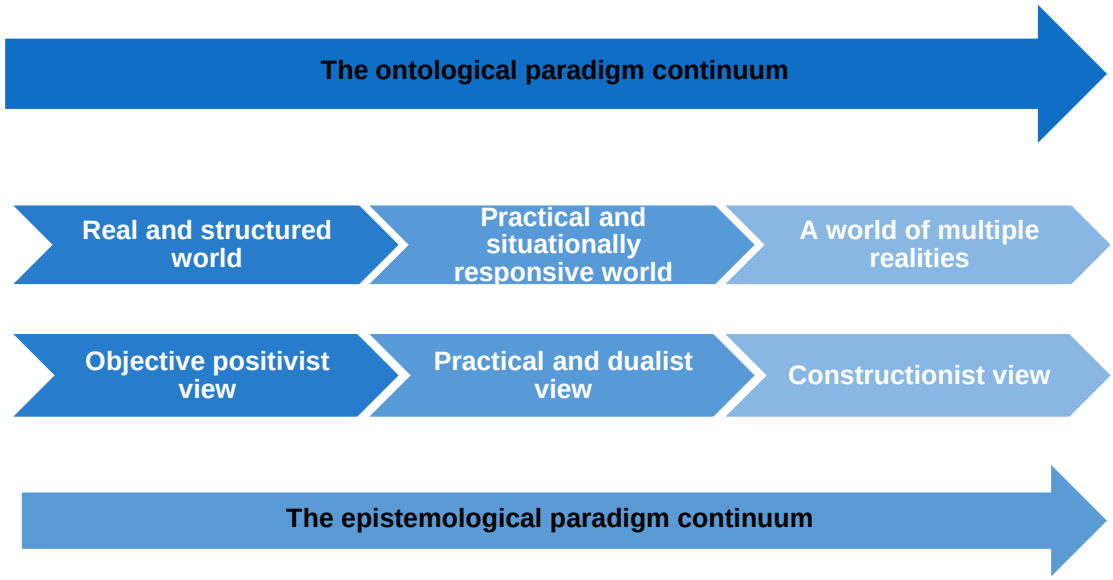
under investigation has been acquired. Bourdieu considers the field to be dynamic as history shapes and orientates the social space and the knowledge generated as a result (Thomson, 2012). From a Bourdieusian perspective, in order to appreciate and comprehend contemporary social spaces it is imperative to consider how the social space has evolved and developed into its current form, as practice is located in social space and time (Jenkins, 2002**).** Likewise, science itself is impacted upon by its historical and contemporary beliefs, suggesting truth is relative to the values and practices that shape scientific practice (Howson, 2009). The purpose of this thesis is to understand the students', mentors' and PTs' lived experiences of practice education, including how they make sense of this experience. The research aim and questions have been formulated to address the theoretical and philosophical gaps in knowledge identified in the literature review through the conceptual lens of Bourdieu's theory of practice. The research questions concern the experiences of the participants, and are therefore best answered through an approach that facilitates deep and meaningful conversation. This necessitates consideration of qualitative methodologies and philosophical positions.

Research paradigms

The term paradigm was developed by American philosopher Thomas Kuhn (1922-1996), defining a paradigm as an integrated cluster of concepts, variables and problems with corresponding methodological approaches and tools (Kuhn, 1962). Research paradigms are sets of practices and beliefs characterised by different ontological, epistemological and methodological approaches and their contributions to research and knowledge (Welford, Murphy, & Casey, 2011). The ontological position of the researcher is the starting point in the research process concerning what they believe constitutes social reality, the real world and what can be known about it (Blaikie, 2000; Denzin & Lincoln, 1994). Aligned to ontology is the branch of philosophy termed epistemology, concerned with the theory of knowledge and how we know what we know, acting as a philosophical foundation to research (Crotty, 2012). Ontology and epistemology encompass differing assumptions of reality and knowledge which underpin the research approach, and this should be reflected in the chosen methodology and methods utilised in the research study and the ontological and epistemological position of the researcher (Guba & Lincoln, 1989). Bourdieu invites researchers to consider their disposition or habitus in relation to epistemology, how their frame of reference has come into being (Grenfell, 2012). Researchers need to position themselves paradigmatically in order to defend their approach, understand other researchers' positions and be cognisant of the relationship of key components

in the research process (Brown, 2011; Grix, 2002). The paradigm therefore not only provides a framework for the techniques chosen for any enquiry, but also has important implications for the perspectives of those who use the research techniques, and the complex web of research knowledge and skills they bring to the research (Sparkes, 1992). Welford et al.'s (2011) imagery of an ontological and epistemological paradigm continuum (figure 3) aided the framing of the current research from an epistemological, ontological and methodological perspective. Ontologically, the continuum to the left depicts a view of a real and structured world, the middle is a world that is practical and situationally responsive, and to the right is an ontological world which consists of multiple realities. Epistemologically, the continuum to the left is an objective positivist view, progressing through the middle with practical and dualist views, and to the right is an epistemological constructionist view.

Figure 3: Diagram depicting Welford, Murphy & Casey's (2011) imagery of a paradigm continuum



Ontological perspectives

As a researcher, there is a need to embrace deep rooted ontological beliefs which if left unacknowledged may affect a given view of reality and importantly how phenomena are interpreted. Ontologically, data analysis is therefore a hermeneutical process infused with elements of culture, identity and tradition which need to be recognised and transparent (Garratt, 2013). This research concerns practice education and as a researcher I have experience in this field, and therefore bring existing experiential and research knowledge to the process of enquiry. The research commences with my point of view, a perspective influenced by habitus and this in turn shapes the way I approach the research process. It is acknowledged that it is not

necessary or indeed possible to free oneself of all prejudice, but it is essential to examine the prejudices we may hold (Kimball & Garrison, 1996). Weber (1864-1920) refers to this as interpretive awareness, when researchers recognise and address implications of their subjectivity. It is argued, however, that human beings can never fully recognise 'prejudgements' and the influence of subjectivity. Bourdieu, Accardo et al. (1999) reject epistemological innocence and the notion of a detached researcher, arguing instead for an epistemological break whereby researchers accept and acknowledge their role and position in the research process, resulting in the co-location of the observer and observed within the same epistemological frame (Jenkins, 2002). Critically informed researchers therefore attempt to recognise the influence of subjectivity, background assumptions and beliefs which impact upon the research process (Garratt, 2013).

My beliefs are mirrored in the professional philosophy of health visiting, and were intrinsically linked to my decision to join the profession. Health visiting is a branch of nursing concerned with the human condition and lived experiences of people; as a discipline, it therefore lends itself to social research. In my current role as senior lecturer, I am in the privileged position of both educator and researcher for a new generation of students, and I bring to the research process the belief systems I uphold. Identity formation can be seen to be a complex process and Bourdieu's concept of habitus can be drawn upon to consider how I have cultural, historical and structural processes embodied within me. My habitus is the internalisation of social structures resulting in the outer becoming the inner. Taylor (1999) refers to this as 'embodied understanding' as we make sense of ourselves. As a previous PT and current academic, I possess economic, cultural, social and symbolic capital which could be used to achieve dominance in the field of practice education and within the research process itself. I am aware of the dominant culture within the field and therefore the rules of the game. This could result in a process of social reproduction which protects the established order, rather than a true interpretation of the social practice the participants are sharing with me. Bourdieu argues for the application of his thinking tools – habitus, field and capital – to be considered by researchers so that they acknowledge their reflexive positioning and location in the research field (Maton, 2008). My habitus has emerged and developed over many years, acting as a durable structuring structure. I am therefore mindful that it predisposes me to think and act in certain ways (Scrambler, 2015).

The philosopher Immanuel Kant (1724-1804) makes a distinction between the 'noumenal' world, reality as it is and the 'phenomenal' world, perceived reality. Kant

does not suggest that these are separate worlds, totally devoid of each other; rather, they converge and the phenomenal world is shaped by our interaction with the noumenal world (Kant, 2006 [1783]). My personal and professional belief system would seem to align with the post-positivist ontological position of interpretivism where reality is subjective. Human beings construct social reality in relation to each other and in ways that will differ from each other; reality is therefore subjective, and although the real world may exist, it is impossible for humans to truly perceive it (Guba & Lincoln, 1994). This interrelatedness of different aspects of people's lives is the focus of qualitative research (Ritchie & Lewis, 2003). In contrast to objectivists, subjectivists focus on the meaning of social phenomena as opposed to measurement; rather than causality, the focus is on the meaning individuals attach to a given situation (Easterby-Smith, Golden-Biddle, & Locke, 2008). As a researcher I am therefore concerned with how the participants construct reality in different ways. Ontologically, therefore, my stance is one of interpretivism, concerned with truth and social reality, as viewed from multiple realities and perspectives as opposed to one absolute truth.

Epistemological perspectives

Epistemology guides the research process, the methods used, how knowledge is generated, what knowledge is possible, and how it is deemed adequate and legitimate (Maynard & Purvis, 1994). Epistemology, therefore, questions the relationship between the knower and the known (Welford et al., 2011). As a researcher, my epistemological standpoint affects the scientific nature of the study, the knowledge reported, and if I am internal or external to the process. Such interaction depends upon my ontological standpoint and this then influences the methodology and method of the research; having considered epistemological perspectives, I consider my stance to be one of constructivism. Within constructivism, it is acknowledged that meaning is constructed as opposed to discovered, and that humans will experience the same phenomena differently and construct meaning in different ways. Constructivism emphasises the importance of culture and context at an individual level as it focuses on the meaning individuals attach to their social context and the resulting construction of knowledge. The individual is therefore the focus of the enquiry; this is congruent with Bourdieu's concepts of habitus, capital and field which consider individual perceptions within the structure and boundaries of social space, the subjective experience of the individual being influenced by the objective structure. Bourdieu is considered to have built bridges between

structuralism and constructivism, terming the phrase constructive structuralism (Scrambler, 2015).

Although Bourdieu's theories are concerned with the exploration of individual perception within the social field, they also recognise the force of objective structure as a constraining factor on practice and the individual. Individual perceptions are influenced by habitus and therefore perceptions of the social field vary from person to person, constituting their subjective experience of reality. However, whilst objective structures act as constraining forces on thought and action, individual representations affect objective structures (Scrambler, 2015). Social constructionism is also concerned with the construction of knowledge; however, constructionism stresses the importance of socialisation and enculturation and current influence as the most active force shaping mutual existence (Owen, 1995). For constructionists, the emphasis therefore is on the shared production of knowledge and the collective generation of meaning (Crotty, 2012). Appleton and King (2002) argue that constructivist enquiries allow researchers to explore the labyrinth of human experience as they live and interact within their social worlds; however, whilst acknowledging that constructivism's primary focus is on the individuals' experience, they also suggest that constructivism additionally takes into account the social interactions that shape and change individuals. Bourdieu considers culture as paramount, using it within his conceptual framework to understand social relationships, structure and the constraints imposed by structure (Jenkins, 2002). This micro perspective is congruent with the interpretivist paradigm linked to individual experience and phenomenology. The thesis research aim and questions are primarily concerned with individual experience and the resulting psychological constructs of the participants in the study. However, practice education can also be seen as a social interaction, the process by which we act and react to those around us (Goffman, 1959; Little, 2016). It is argued, therefore, that the aim of the study is congruent with a social constructivist epistemology with its primary focus on individual experience and the additional consideration of social interaction which is congruent with the ontological stance of interpretivism.

Phenomenology

Phenomenology derives from the academic disciplines of philosophy and psychology concerned with how individuals experience a phenomenon. According to Crotty (1998), research for phenomenologists is the attempt to break free and see the world afresh, aiming to explore and understand the 'lived experience'. Phenomenology as

a methodology draws on two philosophical approaches, those of Edmund Husserl and Martin Heidegger. Husserl (1859-1938), the founder of phenomenology, considered phenomenology to be concerned with the meaning of individual experience and awareness of phenomena; the purpose of the approach is to provide a first-hand description of the participants' experience (Welford et al., 2011). Husserl explored the concept of intentionality, considering that all thinking, feeling, and acting are always about things in the world (Van Manen, 2011). Husserl's descriptive phenomenology is concerned with the participant's voice, with the researcher suspending his belief and experience so as not to contaminate the data. Husserl's background in mathematics influenced the way he defined phenomenology as a scientific study of the essential structures of consciousness. Husserl developed the phenomenological concept of *epoché* (bracketing*),* asserting that any description or truth should be described exactly as experienced by the person (Luft, 2004). The process of bracketing includes rejecting the non-essential, enabling the phenomenologist to focus on the basic rules and processes. Husserlian phenomenologists therefore bracket questions of truth or reality, instead describing only the contents of consciousness as described by the participant, which are not influenced by the researcher (Chan, Fung, & Chien, 2013). Bracketing necessitates a deliberate and conscious effort to ignore any prior experience of a given phenomenon, in order to accurately describe the participants' lived experiences, thus demonstrating the validity of the data collection and analysis process (Carpenter, 2007; Chan et al., 2013). As previously identified in this chapter, the research questions are best addressed through an approach that facilitates deep and meaningful conversation; and as a former PT with many years' clinical experience and prior research experience in this field, I bring this existing experiential and research knowledge to the process of the enquiry. This is an integral element in the research, one which I acknowledge and embrace. As Garratt (2013) states, a critically informed researcher recognises the influence of subjectivity, background assumptions and beliefs; and instead of bracketing this subjectivity, this knowledge and prior experience should be seen to contribute to the research process.

Interpretivism

The interpretivist approach observes both the culture and historical interpretation of the social world and includes hermeneutics, the interpretation of text and unwritten resources; phenomenology, the study of subjective experience; and symbolic interactionism, which focuses on patterns of communication and interpretation between individuals. Interpretivism according to the work of Max Weber (1864-1920)

is a branch of social science concerned with understanding in comparison to explaining: interpretivists emphasise the phenomenological perspective of behaviour and celebrate subjectivity (Guba, 1990). The notion of objectivity in research has been challenged over many years. Kant argued that all methods of analysis are influenced by ontological position, meaning that we never see things as they are but within a framework influenced by our personal experience and understanding (Garrett, 2013). Heidegger (1889-1976), a student of Husserl, developed interpretive phenomenology. Heidegger expanded hermeneutics, considering the concept of 'being' in the world, moving beyond description and seeking meaning instead (Wicke, 2002). Heidegger considered that bracketing was not warranted as hermeneutics presumes prior understanding (Dahlberg, Drew, & Nystrom, 2008). According to Welford et al. (2011), interpretivists emphasise the significance of understanding the meaning individuals place on their actions. The relationship between the researcher and research participants is central and both are equally valued (Horsfall, 1995). In common with Husserlian phenomenology, the phenomena under question are viewed from the perspectives of the participants. However, ontologically interpretivism is about 'truth' being viewed from multiple perspectives and multiple realities (Welford et al., 2011). Heidegger's notions of personal awareness as an intrinsic element of phenomenological research would appear to be congruent with my previous professional experience as a PT, where my experience is seen to contribute to the understanding of the everyday world of practice teaching and the interpretation of the educational experience. As a researcher, I am a knowing subject and therefore there can be no theory-free observation nor innocence (Garrett, 2013). The aim of the research is to understand and interpret the voices of the participants, exploring alongside them the complexity of their lived experience, and as such the aim is to interpret meaning that embodies the gestalt (or form) of practice teaching (Reiners, 2012). As humans, we experience the world through participation and knowledge which is borne out of a reality influenced by social forces such as culture, time, place and historical tradition (Garrett, 2013). When applying Crotty's (1998) methodological framework to the thesis research aim and questions, it is apparent that the intention of the study is to understand how the participants construct reality (see table 4); for the reader's convenience, the research aim and questions are repeated here.

Aim of the research

To explore 2+1 student health visitor, practice teacher and mentor experiences of practice placements and emerging practice education experiences within the

context of the Health Visitor Implementation Plan, through the lens of Bourdieu's theory of practice.

Research questions
Specifically, the research will address the following questions:

- How do 2+1 student HVs perceive and interpret their experiences when placed with mentors and PTs?
- How do PTs and mentors perceive and interpret their experiences when facilitating learning in placements for 2+1 student HVs?
- To what extent can Bourdieu's key theoretical constructs – habitus, field and cultural capital – be used to locate and understand the participant narratives?

Table 4: Crotty's (1998) framework applied to the thesis

Research aim	Paradigm/ theoretical perspective	Ontology	Epistemology	Methodology	Method
To explore the experiences of 2+1 HV students, PTs/mentors and emerging practice education experiences within the context of the HVIP.	Interpretivism	Lived experience concerned with truth and reality viewed from multiple perspectives	Subjective/ constructivist	Phenomenology IPA	In-depth interviews Narratives

As evidenced in the critical analysis of the existing literature, human behaviour, relationships and communication are all seen as key elements of practice education, and much of the research previously undertaken is qualitative in nature to reflect the importance of the individual human experience and its impact on teaching and learning. Having reflected upon both the existing body of evidence with regard to SCPHN practice education and critiqued varying methodological paradigms, it is considered that methodologically the theoretical framework for the research is interpretivist in its underpinnings, aiming to identify a variety of constructs and consensus where possible.

Interpretative research methodology: IPA

Interpretive phenomenological analysis (IPA) is a qualitative approach with theoretical foundations in psychology, phenomenology and hermeneutics (J. A. Smith, 1996; J.

A. Smith et al., 1995), seeking to explore and offer insights into how individuals make sense of their experiences of a given phenomenon, in this instance the participants' experience of SCPHN practice education. IPA has at its centre a focus on the human predicament and as such it is used in fields such as health and social science. The "P" in IPA is concerned with the exploration of participants' personal perceptions of a given phenomenon, enabling the researcher to understand personal perspectives and real world experience, coupled with reflective interpretation (Reid, Flowers, & Larkin, 2005). Phenomenology enables the IPA researcher to study individual experience; without this, there would be nothing to interpret (J. A. Smith, Flowers & Larkin, 2009).

IPA studies are concerned with rich in-depth examinations of experiences and creation of meaning for participants. IPA research has been extensively conducted using flexible, semi-structured in-depth interviews, allowing the researcher to consider each participant's emergent thoughts (J. A. Smith & Osborn, 2008). IPA acknowledges that the researcher's engagement with the participant's text has an interpretative element, whereby the researcher's understanding is utilised to make sense of the participant's experience (Biggerstaff & Thompson, 2008). This double hermeneutic loop offers an interpretation of the participant's interpretation which helps to frame the participant's perceptions (Garrett, 2013). The researcher's understanding is therefore used as part of a process of interpretative activity (J. A. Smith & Osborn, 2007a), with their thoughts and feelings considered explicit and legitimate components of the enquiry. This fits ontologically with the research aim which is interpretivist in nature, seeking to explore the lived experience; it also fits epistemologically as the research is subjective, aiming to explore the phenomena from multiple perspectives (Biggerstaff & Thompson, 2008).

Positionality, insider/outsider research

In order to consider issues of robustness and authenticity of the research, due attention should be paid to the researcher's positionality within the study (Holmes, 2014). As an insider researcher, the need to ensure validity of findings is problematic if validity is used as a synonym of truth and objectivity; however, if it is recast in terms of trustworthiness, relevance and credibility, then it can come to mean something else. My position within the research was explicitly acknowledged to the participants prior to the data collection, and the thesis includes a detailed methodological description and audit trail; this will enable the reader to determine if the data should be accepted as legitimate (Shenton, 2004). As discussed previously, my interest in

the research area has been informed by both clinical and academic experience; this has the potential to influence the study from formulation of the research questions through to the analysis and interpretation of the findings, as it has implications from ontological, epistemological and methodological perspectives. Professional doctorates are, however, concerned with influencing practice, and often undertaken by expert practitioners who possess a wealth of tacit knowledge (Herr & Anderson, 2005). Insider researchers are seen as wanting to use their tacit expert knowledge of practice in order to effect an organisational change (Anderson & Jones, 2000). Hellawell (2006) defines an insider as someone with an intimate knowledge of the community and its members, adopting an insider view whereby knowledge is generated by being part of the research (Flick, 2009). My habitus could be viewed as locating me as an insider researcher, being an integral element of the study and congruent with IPA frameworks which take into account positionality (J. A. Smith et al., 2009). However, as an academic who is no longer in clinical practice I argue that I am an outsider within, as positionality is not only concerned with degrees of collaboration but also social hierarchy and power. Thus, my position as a researcher and insider/outsider is also in relation to the setting of the research and the participants in the study (Herr & Anderson, 2005).

By adopting a self-reflective stance which considers the positional continuum and the hybrid position of insider/outsider researcher, I acknowledge there are power issues arising from an asymmetry of symbolic power and the distribution of cultural capital, and the tensions which could arise if habitus and cultural capital were left unexamined. Morrow (2005) suggests a reflective journal enables researchers to acknowledge biases and assumptions derived from experience and their position within the research. However, it is argued that bias is the language of the objectivist, and reflexivity can refer to a process that acknowledges the conjoined nature of self and other in a research interaction. The pursuit to become unbiased therefore becomes undesirable as it fails to consider the very nature of insider research and researcher positionality. By adopting a truly interpretivist approach, my reflective journal was used to examine and interpret findings through co-construction with the participants; rather than protecting against the potential for bias, it acknowledges and embraces my positionality and reflects upon my own tacit knowledge, exploring rather than ignoring presupposition (Guillemin & Gillam, 2004; Van Manen, 1990).

Research method

The IPA framework utilises a qualitative data approach using interviews and focus groups. For this study eight in-depth interviews were undertaken, remaining true to the philosophy of phenomenology by capturing the individual, personal accounts of the participants (Larkin, Watts, & Clifton, 2006). Semi-structured conversational interviews were conducted using open ended questions which loosely directed the interview whilst at the same time allowing the participants to tell their story in relation to their experience and perspective (J. A. Smith & Osborn, 2003). This enquiring approach encouraged a rich and in-depth narrative which was then analysed to extract meaning and interpret the participants' accounts (see appendix 6 for an extract from one interview transcript and appendix 7 for interview schedule example).

When considering interviews as a data collection method, Patton (1990) refers to the informal conversational interview and the interview guide approach. Both approaches encourage responses which are open-ended and non-restrictive. The conversational interview is bespoke to the participant, encouraging exploration of insights the interviewer may not have anticipated. The interview guide approach entails a brief outline of topics to be covered; however, the order of the questions is flexible, resulting in more control over the data generated whilst the tone is conversational. Kvale (1996) suggests interviews are a conversational exchange, generating specific narratives through discussion in a relaxed and informal manner. Brinkmann (2007) considers this type of interview to be based upon Rogerian humanistic theories which validate private experiences and narratives. Kvale and Brinkmann (2009) refer to the interviewer as a traveller who through conversation encourages participants to talk about their experiences, co-constructing knowledge which is then taken home. According to Hammersley (2012), a conversational approach enables interviewers to explore and probe the ideas and themes raised by participants themselves, as it is this exchange between the interviewee and interviewer that is of significance and meaning.

It is acknowledged, however, that the interviews are part of a research study and therefore are primarily concerned with the promotion of intellectual understanding. Whilst it is argued that the value of qualitative conversational interviewing rests in its flexibility, the interview process still requires a framework which will result in meaningful data being collected (Given, 2008; Kvale, 1996). To achieve optimum use of interview time, a conversational approach was combined with a semi-structured interview format; this enables the researcher to orientate the conversation to the

areas arising from the research questions whilst allowing participants to describe what was meaningful for them (DiCicco-Bloom & Crabtree, 2006; Jamshed, 2014). This is in keeping with Heideggerian beliefs where interpretation and meaning are central constructs (Horrigan-Kelly, Millar, & Dowling, 2016) and my own ontological position concerned with truth and social reality, viewed from multiple realities. The student interviews were conducted within the university setting and the PT/mentor interviews in the Trust setting. Interviews were digitally recorded and lasted on average one hour, a recommended duration for in-depth interviewing (J. A. Smith, Flowers, & Larkin, 2010).

Sampling procedures

IPA studies are often small scale, drawing upon the experiences of one or a small group of participants who have experienced a common phenomenon. Large sample sizes are considered to limit analysis, whereas small sample sizes reflect the idiographic nature of IPA and the depth of analysis required (Reid et al., 2005; J. A. Smith et al., 2009). Brocki and Weaden's (2006) critical review of IPA studies found that the IPA literature fails to reach consensus with regard to sample size with samples ranging from 1 to 35. A sample size of eight is congruent with IPA professional doctorate research which typically concerns four to twelve participants (J. A. Smith et al., 2009). Examples of recent IPA study samples include Giltenane, Kelly and Dowling's (2015) research concerning ten public health nurses' experiences as part of a primary care team; Morrell and Ridgway's (2014) study concerning eight student nurses' preparedness for final practice placement; and Quest's (2014) doctoral study researching the social interactions of ten bisexually attracted young people.

Sample group/inclusion criteria

As the study concerned 2+1 student HV, PT and mentors' experiences of practice placements, the wider group of student HVs recruited from various backgrounds were excluded from the study along with their PT/mentors. The purposive sample consisted of a primary selection of critical cases chosen because the participants all had the necessary knowledge and experience of the relations and the phenomena, and were willing to share this (Flick, 2009; Morse, 1998; J. A. Smith et al., 2009). The sample reflects the specialised area of 2+1 students and the educators who support the placements, and can be considered as a broadly homogenous sample which is in keeping with IPA principles (J. A. Smith & Osborn, 2007b). However, IPA studies can employ a maximum variety sampling technique whereby the participant sample differs

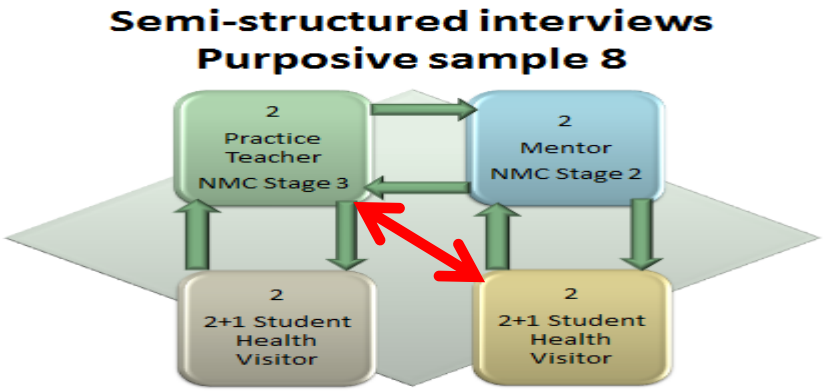
(Brocki & Wearden, 2006; Macleod, Craufurd, & Booth, 2002). This is congruent with the IPA tradition where samples are frequently defined by the participants who are willing to be included, with the specificity of the sample being determined by the rarity of the phenomena under investigation (J. A. Smith & Osborn, 2007a). It was not my intention to link the student data to a particular PT/mentor or vice versa, rather to explore the issues in relation to personal experience, therefore the educators were not necessarily facilitating placements for the students interviewed. Participants were sent an email invitation from the department administrator, requesting they contact the researcher should they wish to participate in the study. Participant information was included in the invitation letter which detailed the aims of the study (see appendix 3, participant information letter).

Sample size

The sample size of eight consisted of four 2+1 SCPHN-HV students, two placed with a mentor and two placed with a PT, plus two mentors and two PTs (see figure 4). All eight of the participants were female and white British. The four educators were employed in three North West England NHS Trusts, two of which merged during the course of the study. The four students were all attending one university within the North West of England and had practice placements in three local NHS Trusts.

Figure 4 depicts the sample structure:

Figure 4: Purposive sample



All four students were registered as first level nurses with the NMC. Table 5 presents their further demographic details; pseudonyms have been used to protect their identities.

Table 5: Demographic information for students

Name	Age	Qualifications prior to commencement	Pre-registration nursing field
Nadia	30	Foundation Degree in Early Years	Adult
Abigail	33	Business degree	Mental health
Veronica	34	Level 4 NVQ Business Management	Child
Helen	46	Degree in Education	Child

The four educators were experienced practitioners with varying degrees of mentorship experience. Table 6 presents further demographic details; again, pseudonyms have been used to protect their identities.

Table 6: Demographic information for educators

Name	Age	PT/mentor	Mentorship experience
Amanda	50	Mentor	Stage 2 mentor, currently mentoring second HV student
Natalie	44	Mentor	Mentored two SCPHN students and has NMC stage 3 sign-off status
Gemma	55	PT	PT for 10 years: Long arm mentors and one-to-one
Sophie	49	PT	PT for 9 years: Long arm mentors and one-to-one

Data analysis

The depth of analysis required for IPA is argued to be more detailed than thematic analysis, warranting deep exploration and interpretation of the idiographic and the collective rather than identification of common themes alone (Braun & Clarke, 2006; Green & Thorogood, 2013; J. A. Smith, Jarman, & Osborn, 1999; J. A. Smith et al., 2009). Recordings were transcribed precisely and accurately (J. A. Smith et al., 2010) (see appendix 6, verbatim interview transcript) and data analysis followed a structured six stage approach (J. A. Smith et al., 2010, p.82), moving from description to interpretation. Table 7 illustrates this step-by-step process in detail. In the initial stages of the analysis the researcher suspended presuppositions and judgements, focusing on what was presented in the transcript data (Biggerstaff & Thompson, 2008). As the analysis progressed, there was more in-depth interpretative activity, including consideration of speech dynamics, pauses in conversation and notes on non-verbal communication. The transcripts were read, reread and analysed in combination with the recordings to elicit key words and emergent themes; this process ensured full immersion in the data as I reflected upon the narratives. Notes

were made in one margin documenting emotions, key words and language, and my own initial interpretation of the discussion.

Table 7: IPA analysis framework

Interpretive Phenomenological Analysis framework (J. A. Smith et al., 2010)	
Framework steps	**The stages applied to this study**
Step 1: Reading & re-reading	Immersion in the original data, listening and recording initial thoughts. Shifting from generic to specific patterns and accounts.
Step 2: Initial noting	Process includes descriptive comments, what is said; linguistic comments, exploring language; and conceptual comments, engaging on an interrogative and conceptual level. Transcripts colour coded: red for description, orange for linguistics, and green for conceptual comments.
Step 3: Developing emergent themes	Larger data set of transcript and notes is the focus. Emergent themes searched for and data volume reduced, still identifying complexity. Analytic shift from transcript to notes. Narrative fragmented and reorganised, gradual withdrawal from participant narrative to my interpretation.
Step 4: Searching for connections across emergent themes	Emergent themes structured in relation to importance and clustered into superordinate themes. Differences and similarities were explored, identifying frequency of emergent themes.
Step 5: Moving to the next case	Process repeated with each participant. Each transcript treated independently as I tried to bracket the ideas which emerged from the previous transcript (idiographic nature of IPA).[8]
Step 6: Looking for patterns across cases	Connections across the transcripts searched for. Themes reconfigured, shared concepts and idiosyncrasies. Table of themes formed, highlighting superordinate themes and the connection to each participant.

Maintaining ethical rigour

The ethical implications associated with this study necessitated ethical approval in order to safeguard the interests of participants including protection from harm, power relationships, informed consent, the right to confidentiality, anonymity, data protection and the dissemination of results. This demonstrates compliance with the requirements of the Council for British Educational Research Association's Ethical Guidelines for Educational Research (CBERA, 2014), Medical Research Council (MRC, 2012) and NMC Code for Nurses and Midwives (2015). Research ethics and governance approval was gained from the University Research Ethics Committee, as the students were all university students (appendix 1), and from the employing NHS Trust of the PT/mentors (appendix 2). Following ethical approval, an information sheet was sent to the participants (appendix 3); this outlined the purpose of the study, the

[8] Dynamic bracketing in IPA terms refers to sensitivity between cases. The researcher aims to understand one case before moving to the next. Findings are set aside between cases as far as is possible (Smith, Flowers, & Larkin, 2009).

associated benefits and risks, and the participants' potential involvement, ensuring participants were able to give informed consent (Denscombe, 2010; DH, 2005). Participants were assured of anonymity, and that the interviews would take place in a private setting.

Participants were asked to sign a consent form that reinforced confidentiality, anonymity and the right to withdraw prior to the interview (appendix 4). The recorded data was transcribed and the files saved in both electronic and hard copy formats. Both hard copy and electronic data were anonymised and stored abiding by data protection procedures (Data Protection Act [DPA], 2018). Upon completion of the study to ensure there is an audit trail (Lincoln & Guba, 1985), all data will be kept for a 10-year period, after which it will be destroyed (University of Chester, 2016). As primary researcher for the study, I was known to the participants as deputy programme lead for the SCPHN programme and lead for SCPHN practice education. This raises ethical issues of power and coercion (British Psychological Society, 2010; Gerrish & Lacey, 2010; RCN, 2011b). Having previously explained the rationale for the research to the participants, the information sheets were distributed by the department administrator; the information sheet asked participants to make contact via email to seek further information or consent to take part in the study. The interviews took place when all of the students' academic modules were completed and marked, and they were aware they were under no obligation to participate in the study. Prior to the interviews, it was emphasised that the narrative would be driven by the participants' voices and they were reminded of their right to anonymity; this was to ensure that the research honoured the integrity of the participants (Cohn & Lyons, 2003). A model of continuous consent was adopted where participants were asked if they wish to proceed throughout the interview, making them aware they could withdraw from the study during the interview stage (Allmark et al., 2009).

In terms of IPA, validity lies in the skills of the researcher and their ability to supply an adequate account of the research process (Hammersley, 1992; J. K. Smith, 1993; Sparkes, 1992). As the body of IPA research increases, so too does the knowledge on how IPA research is undertaken, including transparent transcribing and interpretation (J. A. Smith et al., 2010). Techniques to establish rigour that rely on distance between the researcher and the subject are not applicable to qualitative interpretivist research (Winter, 2000). However, by accounting for the relationship reflexivity can be established, and through supervision values and beliefs explored. IPA as a distinct qualitative approach cannot be judged by quantitative criteria linked to the positivist tradition such as validity and generalisability; however, in recognition

of the need for criteria to evaluate the quality of qualitative research, Yardley's (2008) framework presents four principles: sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance. This framework applied to this study is considered below.

Application of Yardley's qualitative quality assurance framework

Sensitivity to context is demonstrated in chapter one with the review of the literature on health visiting practice education set within the historical and political context, and the research questions which emerged as a result of the gap in the literature. Coherence across the research aim and questions, and philosophical underpinnings, including my epistemological and ontological stance of interpretivism and the appropriateness of Bourdieu's conceptual framework, are considered in chapter two. Chapter three demonstrates sensitivity to data collection and subsequent analysis which I believe demonstrates that the interpretation is grounded in the raw data; this is discussed in relation to existing literature. My engagement with the participants has been considered, including issues of power and coercion.

Commitment and rigour. It is hoped the reader can see the time dedicated to this study and the knowledge acquired as a result. I feel I have a deeper understanding of research methodology and IPA, although I do not profess to be an expert in either. Within IPA rigour is considered in relation to the "thoroughness of the study" (J. A. Smith et al., 2009, p.181); accordingly, I have followed the IPA framework in detail and documented this process throughout. This has included sample selection and data analysis, both of which were true to IPA philosophy which is idiographic and collective.

Transparency and coherence are demonstrated through the documentation of each stage of the study. An audit trail within the thesis includes how interpretations have been reached, supported with raw data in the form of verbatim participant quotes and an ethically sensitive reflective commentary. The audit trail ensures the reasons behind decisions remain open and transparent (Smith et al., 2009; Yardley, 2008). The integration of a reflexive account also demonstrates transparency; considering researcher influences (Shaw, 2010) including positionality is a central concept in IPA research studies. Coherence has been reflected upon in relation to the detailed consideration of methodological fit, including consistency between the research aim, questions, methodology and method; see flowchart detailing key decision making (figure 5).

Impact and importance. The findings will have resonance with educators and students who have experienced or are experiencing SCPHN practice placements, thereby enriching theoretical understanding of the phenomenon through the application of IPA methodology and Bourdieu's conceptual framework. Dissemination of findings is a key influence on impact and in October 2017, the preliminary findings of the study were presented at the Community Practitioners' and Health Visitors' Association conference. Findings may also be considered in broader terms in relation to other professions, offering insights to all involved in practice placements and in relation to the new NMC standards for student supervision and assessment (NMC, 2018b); this will be expanded upon in later chapters.

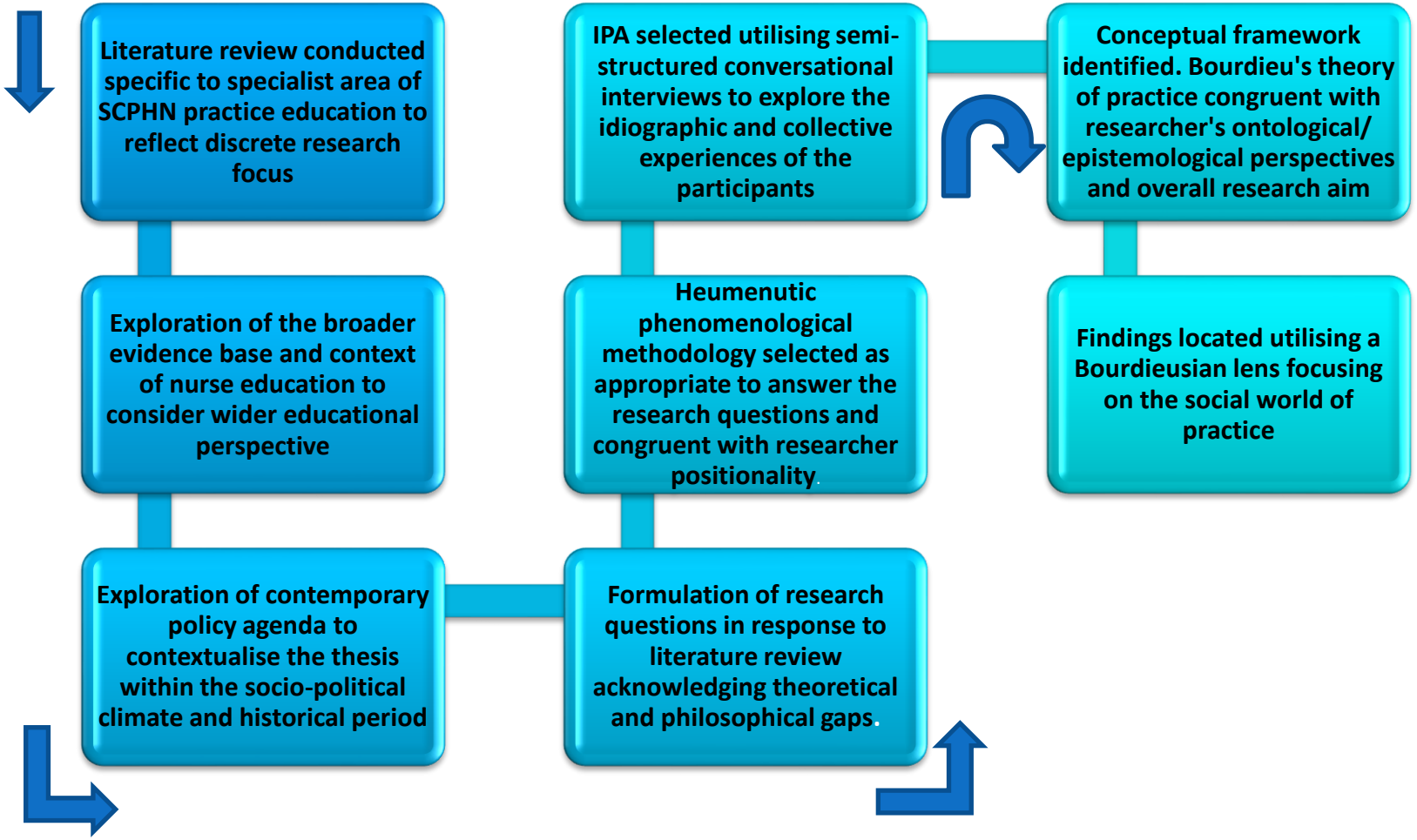
Bourdieu considers that research and commitment go hand in hand, arguing that the researcher should apply the concepts of habitus, field and capital to themselves in order to consider their reflexive positioning and location in the field of research. By using Bourdieu's conceptual framework as a tool for thinking and reflection, I have considered my ontological position, the interpretive research process and my part within it. My doctoral journey in terms of changing habitus has aided this process as I have considered social structure and agency, using this to consider social practice as it was shared with me. As discussed previously, IPA frameworks take into account researcher positionality; however, reducing rather than eliminating preconceptions and assumptions is still desirable (Deer, 2008). Reflexivity enabled me to consider my own perceptions and understanding of the field of practice education; without this, the findings may have been interpreted differently as I projected my own perceptions on to the research findings. Whilst it is still possible another researcher may look at the research data and interpret the findings differently, my interpretation should still be devoid of any unconscious projection of my own relation to it (Deer, 2008).

Chapter conclusion

This chapter has presented the conceptual framework for the study, including an overview of Bourdieu's theory of practice. Research paradigms have been discussed in relation to the theoretical framework adopted for the study, including the research aim and questions. Notions of epistemology and ontology were explored, and the relation of these key concepts to the research process. The theoretical origins of phenomenology, interpretivism and IPA were critically evaluated, and a coherent argument was presented as to why interpretive phenomenology was selected as the methodological framework for data collection and analysis. I consider IPA to be congruent with the study aims as it encapsulates researcher positionality and

reflexivity, and is therefore an appropriate methodological framework for data collection and analysis (J. A. Smith et al., 2009). Bourdieu also considers reflexivity, inviting researchers to consider personal position, beliefs and experience, and how these influence the research process (Bourdieu & Wacquant, 1992). Both IPA and Bourdieu's concepts are congruent with phenomenological methodology which ontologically seeks to explore lived experiences. Bourdieu (2006) considers such an approach highlights the representative nature of each case, and when grouped together with other variants connects the individuals' points of view and multiple perspectives. This is also congruent with the idiographic nature of IPA and a hermeneutic position, whereby data is transcribed and analysed to include phenomenological description and meaningful interpretation (Eatough & Smith, 2008). Purposive sampling procedures were considered focusing on a primary selection of critical cases to reflect the specialised area of 2+1 students and the educators who support the placements. Data analysis was described moving from the idiographic to the collective. Maintaining ethical rigour within the study was outlined, including the exploration of ethical issues such as approval, consent, anonymity, protection from harm, data protection, and issues of power and coercion. The concepts of validity, rigour and reflexivity in relation to the interpretivist paradigm were considered utilising Yardley's (2008) evaluative criteria and Bourdieu's reflexive epistemology. Figure 5 details all of the key decisions made throughout the research process for this thesis.

Figure 5: Key decisions in the research process



Chapter 4: Data analysis and discussion

This chapter presents an audit trail of the data analysis process detailing the findings from the eight transcribed interviews. An integrated analysis and discussion approach has been adopted drawing upon Bourdieu's conceptual framework. Bourdieu's theory of practice is used to investigate the social and individual accounts, enabling connections to be made between the common themes generated**.** The chapter commences with the idiographic data in the form of individual participant narratives which incorporate my interpretation of the experiences of the participants, providing escape from the confining particulars of the data (Pearson-Casanave & Li, 2015).

From an ontological perspective I consider each participant's experience as personal and unique; however, common themes are identified and together with sub-themes are presented and discussed in relation to existing literature, new knowledge, potential implications for professional practice and the conceptual framework for the thesis (Reeves, Kuper, & Hodges, 2008). As the study concerns a corpus of eight, it is important to determine the emergent themes for the whole group. In keeping with IPA analysis, examples are taken from each participant, demonstrating both occurrence across cases and the idiographic focus of individual participants; this process is referred to as case within theme. This demonstrates how participants manifest the themes and the relationship between commonality and individuality (J. A. Smith et al., 2009). Figures and tables are presented to guide the reader through the process of analysis and to provide a transparent audit trail which includes verbatim quotes. Each transcript was analysed using the J. A. Smith et al. (2010) analytical framework. Appendix 8 details step three of the IPA framework applied to an extract from a participant transcript.

The individual narratives

Introduction

The following section provides a summary of the individual accounts, recording the experiences of the participants. This approach will give the reader a window into each of the participant's unique stories. The participant narratives are viewed through the lens of Bourdieu's theory of practice, considering key issues pertinent to the formation of habitus, perceptions of capital and the structural impact on the field of practice education. Bourdieu's conceptual framework is used to develop new theoretical opportunities based on and arriving from the empirical data, enabling me to explore the relations between theoretical constructs and empirical work (Garland & Garland, 2012).

Nadia

Table 8: Nadia's demographic information

Name	Age	Gender	Placement	2+1 Student Pathway
Nadia	30	Female	Placed with a mentor initially	Adult Field

Nadia's narrative

Nadia previously worked for the Trust as a Community Nursery Nurse (CNN) in the health visiting team. Having gained a foundation degree in early years, she entered the 2+1 programme on an NHS bursary, an opportunity which arose as part of the Widening Access agenda and the HVIP. As a mature student, Nadia had acquired accumulated capital in the form of previous educational and professional experience. In Bourdieusian terms, habitus and accumulated capital are viewed as central constructs which when viewed pedagogically are advantageous to the educational journey. Ordinarily, accumulated capital would be seen as beneficial; however, for Nadia this was perceived as problematic, as she felt it affected the support she received as a learner:

> *There were HVs and staff nurses who already knew me… that was sort of a pro and a con because I think they might have been expecting things from me… but I've not been a HV before so I need to learn how to do that.*

The desire to be recognised as a learner was a recurrent theme throughout Nadia's narrative, which is understandable as she had transitioned from CNN through nurse training to HV training in a relatively short period of time. Her narrative suggests a sense of struggle which appears to have been exacerbated by numerous changes within the field, including organisational restructuring and sickness within the team, all of which impacted upon her sense of identity as a learner. Initially placed with a mentor who she had previously worked with as a CNN, Nadia described feeling excited and ready to "*get stuck in*"; her time with the mentor was described favourably and at first her previous experience, acquired capital and embodied habitus were seen as beneficial: "*The benefit of my previous experience opened a lot of opportunities at visits where we did them together… my little history would come back."* She described the mentor as recognising and considering her prior experience and building on this using a scaffolded learning approach; together, they reflected on the practice portfolio and developed action plans as she was socialised into the core work of the HV.

The first contact with the long arm PT was in the form of a card left on her desk on her first day as a student HV. For Nadia, this gesture symbolised the transition from her previous identity as a CNN to that of a student HV, and she described how she felt this change in identity and her new position within the field was recognised from the onset by the PT:

> *It was nice to be thought of as a student coming in, not as somebody who has worked for the Trust before… she knew what I'd done before but supported me as a student HV not a CNN doing extra training.*

Unfortunately, Nadia's mentor became ill and she was reallocated to another mentor in the same office. This arrangement was short lived as more staff members became absent and the team came under pressure trying to cover clinical work. Finding herself in a busy understaffed team, Nadia quickly stepped out of her supernumerary student role, covering work she previously undertook as a CNN and some of the work of her absent mentor. Initially, this was viewed as a positive move by Nadia as she felt this strengthened her position in the team. She recalls being told she was a "*good team player",* indicating the team recognised and valued her habitus. However, despite this affirmation, she recalled being called the "student" which emphasised her position as an outsider rather than the team member they referred to. This reminded her of how she felt as a student nurse:

> *Doing the 2+1 training you get called the student… in health visiting you don't get that…. when I started taking stuff in the team it was oh, we can give that to the student… you feel you're back going up thinking, I'm sat here ask me.*

This was an emotive time for Nadia. Recalling the incident, she became tearful as she reflected upon how her prior experience, though useful to the team, left her feeling unsupported, working against her learning needs: *"With what they knew about my past experience… I felt quite left to get on with it and it wasn't what I wanted… it was a case of so you can just do it".* The long arm PT, despite supporting four other students and mentors, stepped in and took over the facilitation of Nadia's learning. Nadia viewed this positively, speaking in terms of being rescued and protected; she conveyed a sense of relief that someone was taking charge of her learning journey, which is conceivably more crucial when students are on accelerated programmes. In Bourdieusian terms, the PT can be seen to recognise that even though Nadia has acquired cultural capital which is useful to the team, her position within the field is that of a supernumerary student and as such this status needed to be protected:

> *She just snatched me up and looked after me… I felt more looked after… she made me feel more secure, she was very protective, she's quite aware*

> *really… she's just more aware of me… she could see how I was, watching from a distance and then when I needed her she was there.*

The PT and mentor were considered to work well together; however, the student's language suggested that she perceived there to be dominant and subordinate roles within the field. Nadia described the mentor role as being "*responsive to the PT",* suggesting she saw the mentor as an assistant who occupied a lesser position within the field, whereas the PT is viewed as possessing superior cultural capital, being given the title of teacher which carried authority: "*I feel the PT is more authoritative… official, that's better for me, that's how I learn, she felt like a teacher… when I met with her I had to prepare."* The PT as the "*official*" teacher occupied a significant position within the field of practice education and the wider field of the health visiting team. Nadia did recognise the supportive role of the mentor, though this was discussed in terms of complementing the PTs role, providing opportunity for learning "*the mentor provided the opportunities for the things the PT expected of me",* rather than the mentor supporting her learning independently. This sense of the PT orchestrating the placement was clearly articulated when assessment was discussed. Nadia considered assessment to lie in the hands of the PT, describing the PT as gently probing, encouraging and challenging: *"She was always drawing things out from you that you didn't even know were there yourself… everything we did with the mentor had to be seen by the PT anyway*." Crucially, Nadia described the PT in paternalistic terms as having "*mum skills"*; her use of language is noteworthy as although she is a mature post-registration student she reverted to comparing the PT to a mother. This is significant when considered in terms of the development of habitus and the significance of primary socialisation.

In the NHS Trust where Nadia was placed, students are moved for the consolidation period; this was the third change of educator for Nadia and she found this particularly challenging. Finding herself with a new PT and day-to-day supervisor, she described how her confidence was affected:

> *I felt my confidence hit a massive peak coming to the end of my placement, everything was falling into place, I had good support… I had a good PT, I don't know why I got so upset, I just think there's been a big change and it's been hard.*

Nadia described her practice experience as two distinct placements, rather than a continuation of her learning journey. She depicted feeling part of the first placement, voicing a sense of shared habitus where she was beginning to understand the rules of the game and the shared doxa of the field. Bourdieu refers to doxa as the taken-for-granted assumptions (Bourdieu, 1977), in other words the subtly nuanced beliefs

held by the team. The field can be viewed as the base itself, the distinct practice placement, acknowledging that within each base there exists differing shared habitus, capital culture and rules. Prior to consolidation, she felt embedded in the placement area, as the personal connections and the physical environment were all familiar: "*I found it difficult, it's took till now to get to know them and it's been hard with them being different."* Changing bases also meant changing caseloads:

> *I got into consolidation and I was hit with a caseload and no handover, it was, here being your cases, get on with it… I can find things out for myself but I was just a bit like well, what you've just given me, a load of stuff, it doesn't really mean anything to me…. I was pushed back.*

Described in terms of "stuff", this suggests a disassociation from the cases and the new field in which she found herself, a situation which was not aided by a change of PT and supervisor as not only had the field changed but the key players within it. The relationship between the key players of supervisor and PT, whilst not described in wholly negative terms, demonstrates how she was exposed in consolidation to different personalities, differing ways of working and differing habitus. Whilst recognising that everyone has their own style, she found the interplay problematic at times as she was aware these key players were both assessing competence. Nadia felt at times they had differing opinions, and her narrative suggests this affected her developing habitus and sense of accumulated capital, which she described in terms of having her confidence knocked and being pushed back:

> *I was going out with the supervisor at first, who saw my practice, said fine, don't need to observe you, when I'd visit with the PT she said why are you doing it like that? I got very conflicting ideas… my confidence kind of got knocked… it should peak and it was more to do with people expecting different things from you.*

Nadia considered the day-to-day supervisor to be confused with regards to her role: "*My supervisor said you asked me to look after her and I am, but now you've just taken over… interfering".* Her feelings of being moved for consolidation were exacerbated further by what she perceived as being treated differently to student HVs who were seconded by the Trust, having previously worked as staff nurses. These students were not moved and these apparent feelings of inequity were compounded when seconded students were given Trust laptops as they were viewed as employees, whereas as a bursary student she had to fight to use the limited computers at the bases. In Bourdieusian terms, Nadia's narrative suggests that the seconded students were viewed by the Trust as possessing a higher degree of embodied capital than the bursary students; as a result, they occupied a stronger

position in the field and were rewarded with objectified cultural capital in the form of diary covers and IT equipment.

Abigail

Table 9: Abigail's demographic information

Name	Age	Gender	Placement	2+1 Student Pathway
Abigail	33	Female	Placed with a PT	Mental Health Field

Abigail's narrative

Abigail previously worked as a breast feeding support worker and administrator, having gained a degree in business management. Like Nadia, she entered the 2+1 programme on an NHS bursary. Abigail was placed with an experienced PT and she described a positive learning experience. At the beginning of the interview, she recalled the first meeting with her PT, considering how this differed to her experience as a student nurse; she described feeling welcomed by the PT, which made her feel valued. The significance of this first meeting and how the PT used her name was reflected upon; Abigail describes being brought to life as a person, indicating that during her pre-registration placements this was not often the case. In Bourdieusian terms, the PT can be viewed as recognising Abigail as a person with a prior history and accumulated capital which were to be welcomed and embraced:

> *…making a cup of tea, making me feel relaxed, sort of chatty, you know, turning away from the desk to sort of notice I was there, learning my name which was interesting because quite often you're 'the student' when you're a student nurse and you suddenly become a person.*

Abigail's narrative depicts a structured collaborative learning experience where clear expectations were drawn up from the onset, regular supervision meetings were held, goals were set in the form of action plans and they were reviewed regularly and collaboratively. She recalls feeling well supported by the PT and the wider team in the early part of her placement. Her narrative suggests the PT invested time as a mentor, resulting in Abigail feeling *"secure and safe".* She described how the PT used the HCP framework to socialise her into the health visiting profession, drawing upon public health approaches and thereby initiating Abigail into a shared doxa of practice and the internalisation of what is expected of a HV. Abigail depicts the PT as being very structured and experienced, and it is clear she acknowledged and respected the PT's accumulated cultural capital gained over many years: *"I suppose she's got an old school approach… she suited my learning style very well. It's worked very well."*

Abigail refers to the structured yet bespoke nature of the placement throughout the interview, and this was particularly important as she had doubts about her previous experience, her habitus and level of accumulated capital: *"I was nervous… 'cos I'm mental health trained, there were obvious gaps in knowledge of physiology so that was built into the plan, but she was pleased I was most up-to-date with breast feeding support."*

The doubts she voiced with regard to being a mental health nurse were perceived as a consequence of the accelerated two-year pre-registration programme. Abigail suggested she would have gained more knowledge with regard to anatomy and physiology if she had completed year one, rather than joining the programme in year two. These doubts were compounded during her nurse training as she felt mentors did not understand the 2+1 programme: *"It was always assumed that you just knew what the first years had done and that you could move to being a second year because you'd put yourself in that position."* Abigail's choice of words, "*putting yourself in that position",* sounded almost accusatory as if she felt the mentors considered that she had decided she did not need to do the first year, and as a consequence the mentors did not see it as their role to support her into the profession. In Bourdieusian terms, the mismatch between Abigail's learning programme and the way the mentors were trained can be seen to threaten predominant views as to how student nurses should be prepared, challenging the very notion of shared habitus and doxa:

> Doxa is the adherence that is established in practice between habitus and the field to which it is attuned. (Bourdieu, 1990, p.68)

During her nurse training she could not recall being educationally guided or directed: "[It] sounds awful but I don't remember having plans in pre-reg, you did your hours… I had my competencies, that I knew I had to achieve but I don't really remember the mentor directing." This statement suggests a notion of putting in the time, learning the doxa of the field in order to fit in, rather than being exposed to learning opportunities and the chance to develop competence and capital. When asked if the 2+1 programme had prepared her to be a health visitor, she replied "Yes"; interestingly, however, she did not identify herself as a nurse, stating she would have preferred to have trained as a HV for longer via direct entry like midwifery students. In Bourdieusian terms, Abigail considered she had accumulated cultural capital and habitus as a HV, but less so as a nurse.

As discussed in chapter one, the existing literature points to the difficulties associated with the PT role and Abigail had observed some of these difficulties first hand. She described how the dual role of caseload manager and educator impacted upon her PT, alluding to the consequences of increased workload pressures. In the second semester, practice pressures had a major impact on the field as the PT had to take a period of leave suddenly, and this was perceived by the student to be a result of caseload pressures combined with the responsibility of the PT having her own student and long arming other mentors and students: *"It didn't have an impact on me… it definitely had an impact on her and there was a period of time that she had to be away from work because of stress."* Abigail also made connections with the PT's absence and the extent to which the Trust valued the cultural capital of the PT, suggesting that the PT's cultural capital was not institutionally accredited and legitimate: "*There definitely needs to be some recognition for practice teachers."* When the PT was absent, like Nadia she took some of the burden of the work: her supernumerary status was lost as she opted to support the team. She acknowledged that this was largely driven by herself as she did not want to move placement areas, having become familiar with the shared habitus of the team and the local environment: *"I… pushed… to stay where I was… I wanted to learn about my demographic… I was getting on with solo visits and at the time it seemed like a good idea…. I felt more like a team member."* Her need to cling onto the familiar is not surprising if considered in Bourdieusian terms, as she was trying to learn the rules of the game and position herself within the field. Pedagogically, however, this may not have been a sound educational decision as this affected the level of learning support she received, leading her to reflect on whether this was the right course of action: *"I am not sure if it's the most sensible idea. I missed feedback on stuff and there was a period when I was not involved in safeguarding and lost exposure to that through my own choice."* Abigail would appear to have chosen to behave in accordance with the rules of the game as she saw them, as she believed this would strengthen her position within the field: this, however, overrode her learning needs at this time which in the long term may have affected her exposure to different experiences.

During the consolidation period, Abigail remained within the same clinical area with the same PT. This arrangement worked well for her and she described how she was aware students in other Trusts were moved. She used emotive language to describe how she would have felt if this had happened to her: *"I certainly wouldn't want to be moved for consolidation, you get comfortable, you've spent all that time learning, your demographic, their needs, to be thrown somewhere else."* She described how she felt

she was suited to the clinical area, identifying herself with the clientele which she felt was important, and she held a position which she had forged over the previous nine months, which would have been lost had she moved: "*You've got no choice about where it is, where your skill is best met… I think I'm a good person to be here, I meet the demographic of the mums.*" Abigail does recognise that had she moved she would have gained experience of working in two areas: "*You do get knowledge of other areas, but when you're learning it's an extra stress."* Unlike Nadia who was moved, Abigail described a sense of progression and growth during consolidation which was aided by the familiarity of the field. Abigail explained how she had not questioned or challenged her PT's practice prior to the consolidated period, acting as a passive novice. During the extended period of practice, however, the familiarity of the placement area facilitated the growth of cultural capital and habitus. This strengthened her position in the field which gave her confidence to question and seek alternative views, and this enabled the development of her practitioner voice:

> *I think I'm only questioning any of it now cause of consolidation… I don't really know how to say it, not lost admiration obviously, but I was in very much of… she was on a pedestal at the beginning. I just listened.*

Crucially, the PT was described as being open to question and challenge, which Abigail respected particularly as her PT was very experienced. This endorsed Abigail's sense of habitus and developing cultural capital as she felt listened to: *"She's been practising as a health visitor as long as I've been alive, but she thinks about it and realises you know everyone got room for improvement."*

Veronica

Table 10: Veronica's demographic information

Name	Age	Gender	Placement	2+1 Student Pathway
Veronica	34	Female	Placed with a mentor initially	Child Field

Veronica's narrative

Veronica previously worked as a secretary in a primary school, having undertaken a level four business management qualification. Initially placed with a mentor who took unexpected leave after two weeks, she was moved to where her long arm PT was based. She described how this early move affected her, saying she was not sure how long she would stay with the long arm PT or if she would be moved again: "*I was a bit apprehensive… worried as to where I might end up."* She was cognisant that the PT, despite long arming another student, made the decision to move Veronica to her

base rather than have her go to another mentor, and this gave her a sense of feeling wanted:

> *It made me feel… well it made me feel good really that she was willing to… to have me, made me feel wanted, feel more reassured to be honest and maybe… because I was her student anyway, you know, although she was long-arming me I… suppose she was still responsible for me, wasn't she, she wanted to… look after me I suppose.*

Veronica described the PT as introducing her to the core service, taking time to discuss and reflect on visits they conducted together. Mentorship was individualised, gradually building upon the skills she had and those she needed to acquire. Whilst Veronica described a good relationship with both the mentor and PT, she considered the PT to be more experienced and more aware of her learning needs. The PT asked how she preferred to learn, suggesting she understood the significance of habitus and how prior mentorship experiences can impact on learning:

> *I think practice teachers have got… they're more experienced aren't they and they know you've got to do all of those things really…. She's just familiar with what… the students have to do, quite aware she's had quite a lot of students. I don't know, it just feels… different with her, not that there's anything wrong with my mentor, she's really good.*

The notion of safety is ubiquitous throughout the student narratives: the need for security was articulated many times, emphasising the vulnerability students felt as they transition into another area of practice, and the PT was viewed as pivotal to this transition. Veronica described how she felt being placed with a PT meant she would not miss anything:

> *You feel more secure, that you're not gonna miss anything… it's gonna be alright at the end (laughs)… I think, just that guidance, you know, that close relationship to guide you through… be able to reflect back and ask questions whenever you wanted to… yeah, just that support and feedback, you know, positive feedback.*

Veronica acknowledged that her mentor was an experienced HV who had different and complementary skills to her PT, developed in part because of the different areas they worked in. Veronica appreciated the benefit of being exposed to both learning experiences, which were shaped by the individual habitus and capital of the two educators: *"They are experienced HVs and they bring different things… it's been good to have those."*

Veronica described how the PT enabled the development of competence and skills of critical analysis, and of being skilfully challenged as the PT used Socratic questioning to 'delve*',* to reach inside and search for something. The PT is described

as encouraging her to consider herself within the professional context, creating a sense that transformational learning took place, something that enabled her to feel safe when visiting alone:

> *She'd ask and delve deeper, find out how I felt in that situation… be aware of how I'd been… she gave me the time… listened and let me explain, reassured I felt like… she was… even though she wasn't there with me on the visits that she was there and I wouldn't do something wrong because I knew that I could keep reflecting back to her.*

Feeling safe, she was able to go back and forth, building habitus and cultural capital in the process. Veronica described a different approach to mentorship during her nurse training – it was described as impersonal and sporadic, whereas mentorship in the HV programme was described as in-depth and bespoke: *"It's more in-depth, they're with you more and I think they really get to… to know you… what you're like and how you practise… [in] pre-reg, you touch base with them, but it's not the same."* This appeared to also apply to the assessment process – although aware she was being continually assessed, this did not feel intrusive as it occurred as part of a relationship and dialogue which meant nothing came as a surprise:

> *Assessment's more in depth with the health visiting… think I prefer the ongoing, 'cos I think there's less pressure isn't there to perform there and then on that time and day…. It doesn't feel as daunting… I don't think if there was a problem it would have been a shock… feel as if she would have been honest and said something sooner.*

Veronica, whilst positive about her experience, did observe the difficulties encountered by both the PT and mentor as they tried to balance their educational role and service demands. Although this did not impact upon her, she understood it was difficult for both educators:

> *I think it's a lot of work really… for them to… be able to spend the time, you know… to just talk things through because if they've got a full caseload it's difficult, they always seemed to manage to make the time but yeah, sometimes it was difficult.*

Veronica was moved for consolidation, but she returned to the mentor where she was previously placed. Outwardly she knew the team, she had the same mentor and long arm PT; however, if placements are viewed in Bourdieusian terms as separate fields of practice with differing cultural capital and shared habitus, then this may account for why she felt this was a retrograde step: *"Feels like starting again… you're taking a brand new caseload, the leaflets, even they're different… even though it's the same Trust it's… still different really, yeah."* Coupled with these differences, she also identified with the clients and the area she had previously worked in, as she had built

relationships and acquired knowledge of the local area and health needs. This can be considered in terms of accumulated capital which she felt she lost when she was moved: *"I'd rather stay I think for security and because you've built your caseload up."* Security and safety are recurrent themes throughout the student narratives. Security is both an intellectual and emotional psychological construct: when individuals feel safe they are more capable of agency, being able to co-produce within a group they feel part of (Wanless, 2016). When an individual perceives themselves to hold low status, in Bourdieusian terms having limited capital, they are less likely to feel safe; psychological safety therefore is key to an effective workplace (Edmondson & Lei, 2014). Veronica does, however, reflect on the experience of working in two areas, seeming to suggest that on a personal level staying in one place would have been preferable; nonetheless, moving was better from a professional stance and ultimately now she is more settled – she has, in fact, gained capital: *"For experience, then, moving has actually been better, yeah."* Despite earlier reservations, consolidation was a period of growth, and she acknowledged that she has acquired many skills, reinforced by her interactions with the PT:

> *It was nice to know that when I'd say, oh this is what I think, that she would agree with me… that then that made me think oh well, I do know what I'm doing (laughing). I do think there's a lot of soft skills in health visiting, isn't there? It's not like clinical, you know, this is what you do and it's this way, it's… it's quite individualised in a way and it's to do with communication and listening and… picking up on subtle things.*

Veronica's narrative described how her identity as a 2+1 student was problematic particularly during her pre-registration training. It was apparent that this did not stem from a negative notion of self-worth; indeed, she articulated a developed sense of habitus, regarding the cultural capital she held to be valid and comparable to others. Rather, she felt the accelerated programme was disapproved of by practitioners in the field, who viewed her training and by extension herself as inferior to traditional pre-registration students. She explained how she purposely hid her identity, and that this time became a period of concealed habitus in a bid to secure a comparable position in the field:

> *I get the impression people don't like 2+1 students. I felt like I've had to prove myself all the time, by the time I came in to my second year, which is the third year, I never told anybody (laughs). I just… didn't tell people, no, if I did I'd feel they'd question me or they'd think I wasn't as good and I thought no… I am, you know, I am. I can do it. So don't expect anything less of me than the others.*

During the health visiting placement these feelings of being viewed as being of lesser worth continued. The HVIP having widened access resulted in the Trust supporting a

combination of bursaried 2+1 students and seconded students who were previously community staff nurses. Although ultimately they were all student HVs undertaking the same programme within the same practice area, Veronica described how the seconded students were regarded as employees of the Trust. As a result, she like Nadia felt they were afforded superior treatment, with the bestowing of objectified capital in the form of diary covers and laptops. In Bourdieusian terms, embodied and institutionalised capital set the seconded students apart. Crucially, Veronica felt they occupied a secure and permanent position in the field which translated into posts:

> *There were three that were community staff nurses before, they'd been arranging things just for them as well… so I think the rest of us out in practice felt a bit sort of… I don't know, uncomfortable, they had laptops and things to do their work on and we didn't, we were second best, we weren't part of the Trust, everything of ours was temporary and theirs was just proper… even our email addresses and log on details were all temporary even though we were there for a year... think it made me feel as if I wasn't fully part of the Trust. I think it was quite clear really even when it came down to jobs.*

Veronica did, however, feel her PT had changed her mind regarding the 2+1 programme. This was said in an almost childlike manner, perhaps hinting at her need to belong, feel accepted and valued: *"She gave that impression, she didn't really like it… I'd like to think that I've proved… 'cos… she says that I'm a, you know, really good student."* At the end of the interview she described feeling well prepared by the mentor and PT, and although a mature student the support she was given proved pivotal in building her sense of capital: *"I'm ready, yeah…. When they believe in you, when they both believe in you, then you do, you realise you can do it."*

Helen

Table 11: Helen's demographic information

Name	Age	Gender	Placement	2+1 Student Pathway
Helen	46	Female	Placed with a PT initially	Child Field

Helen's narrative

Helen previously worked as a nursery nurse before undertaking an education degree. She was placed with an experienced PT in a large office, divided into geographical teams, but unfortunately she was moved after a few weeks as her PT was given another student to support. Although in the same office, Helen's new mentor was in a different team whose members initially were not welcoming:

I was quite settled where I was… it took me a bit out of my comfort zone… I had to work with another team who weren't as friendly at first, I found it a little bit difficult. Not anything to do with (mentor)… she was fab… I did talk to (PT) about it and said… I'm not complaining, but it's not the same on the other team, it's not as nurturing, I craved to go back to… to my normal team.

The new team treated Helen differently, including in the way the physical environment was configured. In the second team she felt peripheral:

I felt shoved out a little bit, with the team with PT I had somewhere to sit, everybody made me feel welcome. I felt like a colleague, but when I went to the other team I felt like a student. I was shoved on the end with no computer thinking oh this is awful.

She recalled her first lone visit and how nervous she was, and on returning to the office she was disappointed that the team failed to recognise the enormity of this step for her. This was compounded by a busy mentor and she pondered if the first team would have reacted differently:

I came through the door, nobody said how did it go? I am a bit of a sensitive creature… but I did wish somebody'd said how did it go… she was busy. It was only an instant feeling… but that was quite significant for me. I did think… I wonder if that'd been different on the other team.

Despite initial concerns Helen depicted her mentor favourably, expressing how much she learned from her. Bourdieu (1984) considers the educational system as a transmitter of inheritance[9] (see further discussion later in this chapter) whereby cultural capital is transmitted across generations. Learning occurs through familiarisation as players in the field unconsciously acquire the principles of an art, resulting in education which is deemed valuable and legitimate within the field (Bourdieu, 1990; Bourdieu & Passeron, 1977; Grenfell & James, 1998). Through Bourdieu's lens the cultural capital of the mentor can be seen to be emulated and transferred: "*I still use that patter, she'd give me sort of top tips quite a lot. I got a lot from her."*

The mentor's capital was also valued by the PT; colocation meant they knew each other well and the PT recognised the mentor's contribution to learning. This positive message was relayed to Helen: *"The PT said to me (name), got lots of midwifery experience and that was one of my needs."*

Helen explained her mentor had decided not to continue in the role because she could not balance caseload responsibilities and mentorship. Unlike the PT, her mentor did

[9] Bourdieu emphasises the role of education in social reproduction, and that cultural capital in the form of knowledge, and habitus in the form of values and attitudes, are all transmitted by the dominant class.

not have a reduced caseload which implies the Trust valued the PT role above that of mentor. The reduction in caseload can be viewed as a form of symbolic capital:

> *I did a presentation for the team leaders and practice teachers. My mentor couldn't come to that... she was supposed to but she couldn't, she apologised and said… I've realised actually I can't do both, I feel like I've missed out because I couldn't fit everything in.*

Towards the end of the programme Helen returned to the PT. This was welcomed as she felt the PT was very experienced which made her feel safe: "*She's got all that experience, making sure everything I needed to do was ticking along… I think she felt I was her student, she needed to make sure that I got everything that I needed… I could have easily got lost*." Helen's narrative suggests she made a distinction between the roles of PT and mentor: the PT was viewed as managing and directing her towards qualification, whereas the mentor was viewed as exposing her to the skills she would require when qualified. When it came to assessment she never felt doubly assessed, though considering the PT to lead the assessment process. This suggests she viewed the PT as possessing more capital than the mentor. At times, however, having two individuals involved was confusing:

> *My mentor's role was to expose me to health visiting… give me skills, the PT guided me to qualification and the paperwork side of it… I saw PT more as she knew the programme, what needed to be done, she would check up on me… I was doing some things with (mentor) and then PT would say… have you done that with (mentor) and I'd think I don't know who I've done it with.*

Helen found the health visiting programme both transformational and difficult, using the synonym of an emotional rollercoaster to describe her experience. This implied she experienced alternating emotions; her PT recognised this and provided a sense of equilibrium, always there to reassure:

> *It's been brilliant… intense, but I've had the biggest learning curve… but an emotional rollercoaster… I've found it quite a traumatic course… you just need that person to say you're doing really good and that brings you back up again.*

Having worked previously as a professional, Helen described how her PT maintained a professional rather than personal relationship, which included role modelling how she expected Helen to contain her emotions in the workplace, rather than letting them impact upon her practice experience:

> *I did feel quite overwhelmed on occasions… I couldn't blur those boundaries but there were times I… wanted to cry and say I'm having a really awful time, times when I could have done… with arms thrown round me but I understand why that didn't happen, I think (PT) was trying to teach me there's a place… keep your personal life and your professional life separate.*

There is a sense that Helen also wanted to hide her inner turmoil in order to protect the PT's perception of her and the position she hoped to occupy upon qualification. By hiding this aspect of self, she therefore protected the outward projection of capital to the key player in the field:

> *I knew (PT) was assessing me and… I didn't want her to think I was this woman that was crumbling underneath… to expose myself… as this woman that's crying all the time… I kept thinking ultimately I need a job, I can't let them see that I'm struggling because… otherwise I won't get employed.*

During consolidation Helen remained with her PT, and having built social capital in that area, she was able to self-actualise. She described her experience of consolidation in positive terms; here she acknowledges that acquired capital prior to the programme made the necessity of experiencing moving teams redundant:

> *You're still learning, you… don't have everything slotting in to place. I would have hated it (moving) because I blossomed… it's too much. trying to fit yourself in somewhere else with different characters, weighing up all those dynamics… it's quite cruel actually... we've been… working before so we know what it's like to have to bed yourself in to a new place… it's not like it's a skill you've never had.*

Having completed the academic programme at the time of the interview, Helen was relieved she could focus on practice, as at times she had felt overwhelmed. In Bourdieusian terms this is significant, as the high level of cultural capital she already held in the form of two first class honours degrees did not mitigate the feeling of pressure. She did, however, imply the experience had been character building, suggesting the difficulties encountered had been habitus shaping:

> *I remember when everything was really, really stressful with academic work… and I remember thinking… this is just awful, again consolidation was great yeah, I used to think god, I can't imagine me even saying yeah that's fine 'cause I wouldn't be able to do that… I can, I can do it.*

Reflecting on pre-registration mentorship, she felt this was affected by the overall structure of the NHS and staffing levels which impacted negatively upon learning. This resulted in learning being a lower priority than clinical care. She described the learning process during her post-registration SCPHN programme as being managed by the PT, relating how learning was personal and directed. She implied workload pressures during her pre-registration period made this impossible at times:

> *It's so busy… your assessments aren't done, it isn't anybody's fault, I've had lovely mentors, but you almost feel a nuisance… you have to ask them to do assessments and that's not because they don't want to, they don't have time… whereas PT would say right we need to do your mid-assessment, let's book it*

now… PTs captured every moment… it's personal learning… with nursing it's… who's got the time to fit you in.

Helen felt she was nurtured as a student HV, which is significant in terms of cultural capital as it could be viewed that pre-registration nursing students may warrant more nurturing generally. Bourdieu considers cultural capital in its institutionalised form as credentials and qualifications (Bourdieu, 1986), which in turn dictate position within the field; a student nurse, having by definition less experience in nursing, would be seen to have less capital than a student HV. This sense of nurturing in SCPHN was said to extend into academia: *"It's massively different… you're more nurtured on the SCPHN programme. The lecturers are more nurturing… I'm not slagging off the nursing programme, it was just a different experience."*

As a 2+1 student she described feeling less worthy than traditional students and the accelerated pre-registration programme left her feeling a lesser nurse. Crucially, Bourdieu views capital as having the potential to cause inequality as some forms of capital are more valued than others (Bourdieu & Passeron, 1977). Omitting the first year of pre-registration training implied she held less capital than traditional students, as her rich and varied history was not recognised as cultural capital:

The 2+1 thing was more of an issue when I did my nursing… you felt like you weren't a real nurse… people said, oh I did the traditional three years, got a lot of that… some of the district nurse students were you've done all your nursing in two years?... you felt a little bit like you were not quite as qualified as some others.

Bourdieu (1984) refers to the individual being reminded of the singularity of his social condition by comments from others. Words such *as* stigma and cheating were used to describe how others viewed the 2+1 programme, clearly having an effect on Helen. These are emotive words, stigma denoting a mark of disgrace which seemed to emanate from a feeling of short circuiting a system that was well established and regarded as sacred, while cheating implies she felt that *they* felt she had acted dishonestly and unfairly, affecting her feeling of worth, value and position:

There was a bit of a stigma with it… you know; how dare you get a nursing qualification in two years when I've done it in three, people think you're cheating your way in. You're not a proper nurse… you've come in half way through. You felt embarrassed, it was like (quietly) oh I'm a 2+1 student… it wasn't very nice that at all…. Horrible, oh god they think I'm not worthy.

Importantly, the PT and mentor never made her feel this way; they recognised her embodied capital as part of habitus developed over many years, using this as a foundation on which to build:

They said… you've got all of that experience listening… and communication skills with families and… attention to detail, I remember PT saying I can teach you the other things… because you've had all of those life skills… that's something that is amazing, you're appreciated in the SCPHN course for those abilities… and that's really nice.

Amanda

Table 12: Amanda's demographic information

Name	Age	Gender	Mentor experience
Amanda	50	Female	Mentor: Currently mentoring second HV student

Amanda's narrative

Amanda is an experienced HV, mentoring her second student, having previously mentored one student through to sign-off and one student who left the programme early. The HVIP gave her the opportunity to gain stage three mentor status and she was in the process of completing the stage three portfolio. Amanda was previously a qualified teacher and when she became a mentor she described being well supported by an experienced PT. Amanda described how she facilitated learning, beginning with induction processes; she recognised that the student was entering a new field, and as such had to negotiate and learn a new set of rules in order to settle and be confident enough to learn:

It's about sharing all that information… finding a place within the team, it's about confidence building, the only way you learn is to feel confident and feel part of the team, settled in well and then you can begin to learn.

Amanda described a gradual exposure to practice, involving observation and role modelling: "…*learning on the job… a step by step process".* She also explained that whilst she was there to share information, she was not there to "*spoon feed"*; there was an expectation that students took an active part in their learning. Amanda considered that mentors need to be *"competent and safe"* practitioners, describing herself in terms of a conduit between the university and the NHS, her role being to maintain standards whilst recognising having a student improved her level of knowledge:

You're in between University and… we've got to protect public health, we've got to know exactly what we're doing and why… I do like having a student… you think more… you go through all the policies and you think in a more detailed way.

Amanda described a symbiotic relationship. As a result of researching evidence and staying abreast of new initiatives, she added to her cultural capital and in so doing

improved her position in the field: *"You've upped your game, it does keep you on our toes."* She can be seen to use her experience of the academic programme to break down learning into component parts, describing how she would reflect with the student following visits, and share ways of managing visits and approaching issues. She also described how her knowledge and skills were being translated and transferred to the student, scaffolding the student's learning; in Bourdieusian terms, sharing habitus through a process of transmission and reproduction:

> *When you've been doing it for a while you've got that experience, you know the questions to ask, you know how go with their agenda and come back to it and sometimes they can get foxed by things like that... so it's sharing with them how could you possibly remember all these questions, the paperwork…*

There were some difficulties associated with mentorship: she appeared to struggle in terms of how the relationship between herself and the student was framed, wanting to establish a relationship that was close enough to teach whilst being slightly distant. The one-to-one proximity and intensity of the relationship for her implied a degree of friendship which she did not want to foster, wanting to keep the student at arm's length, whereas the PTs interviewed missed the close proximity of one-to-one mentorship:

> *You don't want to be treated and seen to be as a friend, it's more… erm… it's still an informal relationship because you're teaching with them, but you still want to be erm… not kept at a distance as… such really but you want to keep that sort of step away… it was difficult.*

Despite prior teaching experience, Amanda found one-to-one mentorship intense, time consuming and constant. This suggests that mentors require support when undertaking the role whatever accumulated capital they possess: *It's quite different than teaching a class… you're with that person all the time... with very little breaks… all the time you're reflecting, I still found it difficult."* Amanda described how the practice area was impacted upon by the current financial climate, with resultant structural changes such as a move to bigger teams and fewer bases. Amanda acknowledged the impact this had on team members wanting to shield the student from this turmoil. Her narrative described how the habitus and doxa of practice were disrupted, recognising this could affect student learning:

> *You want to shield them a little bit… it's difficult, isn't it, doing a health visiting course, doing the study, the practice… you don't want to give them added pressures and you don't want them to see the negative side of anything… going through a period of change it can come across negative… we've gone to four big teams… when we did have a little bit of a wobble… I think I've got a responsibility to try and contain that impact on her.*

Organisational change can be seen to doubly impact upon Amanda, as a practitioner undergoing changes and as a mentor trying to protect the student from a detrimental situation. Pressure is a recurring word throughout her narrative: pressure to get the student to specialised level, pressure to protect the student's learning, pressure from understaffed teams who wanted to offload cases. Consequently, she struggled to balance all of the different priorities. Amanda described how teams frequently did not appreciate mentorship, and as a result her position within the field and the capital she held went unacknowledged. Team leaders prioritised clinical work and as a mentor she had less worth than PTs:

> *It's difficult, stressful, they don't realise the level of responsibility… you get pressures from the team because they're looking to have somebody carry out visits… some team leaders think it's not a priority… don't value what you're doing which is really annoying, frustrating.*

In keeping with the extant literature, Amanda could not balance her dual role; this was compounded by the increasingly busy work environment and no reduction in caseload. In a bid to protect the student's learning, she concentrated on the student's needs when she was in practice. As a consequence, she worked at home and this can be seen to have affected her work-life balance, increasing feelings of stress:

> *You don't get on top of your work on those two days… you find that you do work at home. You still get a full caseload, you feel a little bit stressed… it's full on with the student… you focus on the student. It's containing everything, isn't it?*

Amanda considered the 2+1 students' lack of nursing experience was a deficit she had to manage, and she tried to develop their cognitive, decision making and assessment skills. Crucially, she reflected upon the HV role, questioning whether the students understood the level of decision making required. There is a sense that she was concerned that the 2+1 student when qualified would leap frog from student to manager without the experience of working as a staff nurse, in Bourdieusian terms a rite of passage where they become aware and part of the doxa of practice:

> *They haven't had the staff nurse role where they've had that level of responsibility… in terms of thinking… you wonder if they had sufficient training because they're not showing the levels of confidence that you would expect… you're going for a band six job… that would be a ward manager, I don't think they always appreciate that.*

Amanda reflected upon the 2+1 student who withdrew from training; speaking with a sense of regret, she described how the educational team did not tailor the training to the student. Her narrative depicts an inexperienced mentor mentoring an inexperienced student with rigid expectations as to when milestones should be

achieved. Now more experienced, she recognises this, which fits with the extant literature concerning mentors requiring time to develop confidence (Sayer, 2011):

> *I think it's a shame… our expectations were too high; she would have needed an action plan, but it's having the confidence to think, well actually we need to extend the time in which she observes a bit longer before she's doing visits herself… students are individuals, aren't they?*

Amanda felt being mentored herself worked well when she and the PT were co-located, as this improved access to support and communication. As colleagues, the PT knew her as a practitioner and was also aware of the day-to-day workings of the team. Through the lens of Bourdieu, the PT understood the field of play, the positions of key players and the power relations inherent in teams:

> *The PT in the base worked better… knew the issues… the people… the PT doesn't necessarily know what's going on in my base… it's having confidence in me as a mentor isn't it, if you're in a different base… you're probably wondering what's happening over there… I prefer somebody in the base so she can support me.*

The PT and mentor also shared the same team leader, making logistics easier as there was one manager involved. When the PT long armed from another base, the field became more complex, with more players, positions and power struggles. She described how currently the PT does not know her well – their relationship was seen as taking time to develop and this was acknowledged by the PT as well:

> *She said to me am I gonna to mentor next year, because we know how each other works, it's hard isn't it because we're new at doing it together, I might have to take a student through for her to feel confident that I can do the job.*

In reality she was describing a situation where they were all experiencing new processes – the mentor, the PT and student, all learning new rules of the game.

Amanda felt she was assessing the student and the PT was verifying (proving the truth of) her assessment. This included the consolidation period where she felt the student should stay with her rather than be moved. She described how she missed out on seeing the students complete: "*I miss out that little bit because they move… I'm not there for the finish… I think it's a shame… it's not the whole… process. I would prefer them to stay for consolidation."* Her narrative also suggests a power struggle between the PT and the mentor. Amanda as an experienced autonomous practitioner is used to making complex judgements daily. Now mentoring her second student, her sense of cultural capital has grown, she is more confident and seeks control:

> *Oh yes I do feel like I am assessing, oh yes because I would raise concerns if I felt that she wasn't competent… I do feel that I am assessing the student*

and I'm doing all the paperwork and I'm assessing… I'd say that (PT) is verifying what I'm doing rather than assessing.

Significantly, when asked who the student feels is doing the assessing she refers to a higher level assessment and the significance of sign-off, suggesting she did think there was a difference between her assessment and the PT's:

They probably think the PT… she has the sign-off you see, that's the difference isn't it… she's signing practice off, I'm not signing-off. I do prep a little bit before… to make sure they feel confident… 'cos you do think it's an extra… a higher level assessment (laughs).

Despite undertaking further training, Amanda felt she would not be offered a PT position. She described how she was doing the same role as the PTs before the HVIP, but without remuneration. She reflected on the disappointment she would feel if the skills she had acquired were lost. In Bourdieusian terms, the PT title is the outward projection of symbolic capital, and as such it is understandable she seeks to be recognised as a PT:

You don't get the same recognition, even though you're doing the job the PTs were doing… you don't always get asked to be a practice teacher… I think they worry that you might ask about getting paid… I would like to carry on even though you're not getting paid… it's gutting really… I've done all the training and quite a lot of hard work… and you think ooh, I would like to be recognised as a PT.

Natalie

Table 13: Natalie's demographic information

Name	Age	Gender	Mentor experience
Natalie	44	Female	Mentor: Completed two years as HV mentor

Natalie's narrative

Natalie is a stage three mentor having completed a level 7 module and stage three portfolio. The HVIP was the catalyst for becoming a SCPHN mentor and whilst welcoming the opportunity to develop her teaching skills, she viewed the Trust as accepting all who came forward to be a mentor, implying mentor roles were allocated based less on suitability and more on necessity: *"I've always enjoyed teaching students as a midwife… I volunteered and… maybe three or four of us went along and I think most were picked… it was a needs must, they had so many students they had to train.".* Natalie had been a HV for three years and she described mentor preparation as minimal, instead relying on her own experience of being a student HV, mirroring how she was socialised to professional practice:

> *I mainly used my own personal experience having recently qualified… the overwhelming sort of guidance and voice that steered me was my own practice teacher's, how she mentored me. I used that as a framework, but it was very much make it up, work it out for yourself.*

Natalie had a positive experience as a student HV which she drew upon. She was also supported by a long arm PT who was co-located and was also coincidently trained by the same PT as her. Natalie described this relationship positively, feeling they approached teaching in the same way which was a direct result of their own training, a form of cultural reproduction and transmission of inheritance whereby cultural capital was transferred:

> *I do mine exactly to carbon copy how my practice teacher taught me… actually that's another relevant point because my (long arm) PT had the same PT as I did so actually we both practise in a very similar way… her fundamentals are probably the same as mine… we're a legacy you see.*

Described in positive terms as a legacy, Natalie felt this shared habitus was beneficial. However, this can be viewed as problematic if considered in terms of a monopoly on the knowledge deemed as legitimate and worthy of transference:

> The relation of pedagogic communication within which pedagogic action is carried on tends to produce the legitimacy of what it transmits, by designating what it transmits - by the mere fact of transmitting it legitimately - as worthy of transmission, as opposed to what it does not transmit. (Bourdieu & Passeron, 1977, p.22)

Natalie described being mentored herself, having a PT in the same base, as positive as they shared the same clinical environment and there was an established relationship. She spoke in terms of being the PT's student: *"It was very reassuring… because I was already stressed with my caseload… I think your relationship with your student is… as important as a… mentor-practice teacher relationship… I was her student really.*" Natalie had been mentored by the same PT for two years and she felt this strengthened their relationship. By student two, she felt the PT was confident in her assessment skills:

> *You're on the same wavelength… you're looking and you're assessing the same… in tune with each other by student two… I had my student for eighty per cent of the time and she was observing twenty per cent.… I felt she was confident in my assessment of my student and she was observing what I'd already told her.*

Considering assessment of practice from the student's perspective, she felt students may find having a mentor and PT difficult as whilst it means having two individuals contributing to the student's learning, it also exposes them to two approaches: *"I think*

at times she probably found it confusing, we've all got that infrastructure, that basic framework like a birth visit, but we all interpret it differently."

Despite a good relationship with her long arm PT, Natalie described encountering considerable difficulties: the clinical area was complex, many of the HVs were newly qualified, and she described trying to protect newly qualified team members by taking complex cases, indicating through the lens of Bourdieu that she recognised they were still acquiring cultural capital: *"It was all of the safeguarding I'd accumulated before I got my students… we were all in the same position and we'd got lots of newly qualified girls who we were trying to protect."* The HVIP, although increasing HV numbers, resulted in an imbalance of experienced and inexperienced practitioners, and this resulted in Natalie carrying a full caseload with above average numbers of safeguarding cases whilst also trying to mentor 2+1 students entering the field with generally less nursing experience. This was exacerbated further by the number of students the placement was accommodating; she described this in terms of drowning which highlights a lack of autonomy over her day-to-day practice: *"We were awash with students as well as student nurses coming through as well, it was overwhelming."* Natalie felt that whilst the mentor role was recognised by the team, they were unable to take cases from her. This had to come from managers and was not forthcoming: *"They couldn't protect me… because they were so busy… that needed to come from higher up… to give it that gravitas."* Natalie believed that the practice environment had become more complex and as a result being able to protect teaching had become more difficult. This is crucial when considered against the need to support inexperienced mentors, new in role: "*I felt my one-to-one PT was nurtured, that position was recognised within the team… the team helped to facilitate that learning experience for the student because there was one practice teacher and one student."*

As a result of supporting 2+1 students with limited experience, no reduction in caseload and supporting inexperienced colleagues, she felt the students' learning experience was not always structured as well as it could be. Using emotive language, she described the reality of her day;

> *The relentless grind of just going from one to the other without being able to reflect, no breathing space at all… a very, very stark contrast to how my PT had been able to mentor me, we'd had breathing space, chance to reflect, I was dragging my student to every single visit with me because my diary was chocca block full, we were seeing things probably back to front, I don't think much consideration was given to moving the students and the mentors round to facilitate better learning.*

It is perhaps unsurprising that Natalie felt relieved when the HVIP came to an end. Feeling overwhelmed by her clinical commitments, she described being determined to give her student a good experience, however in keeping with much of the existing literature this meant she had to take work home:

> *It was a relief at the end… and it wasn't the calibre of student, it was my heavy caseload. I wasn't gonna short-change my student, so I had all that on top of my caseload and I wouldn't let either suffer... I was overwhelmed by it, I stayed late… admin for my student I did at home… I had no protected time at work.*

Having previously mentored an experienced HV student, Natalie recognised that all students have gaps in knowledge; however, she considered working in the NHS as a qualified nurse gave students the ability to case manage. She acknowledged the 2+1 student had worked as a professional; however, this was outside the NHS and Natalie described how she felt the NHS was a specialised area – in Bourdieusian terms, a distinctive field with its own doxa. The experienced student had been socialised into this doxa and as a result she had developed habitus as a direct result of working in the NHS. This meant she had already acquired capital which initially placed her in a stronger position in the field than the 2+1 student. Natalie was keen to emphasise that despite this the 2+1 student at the end of the programme had also developed capital and in her opinion the gap in knowledge between both students had narrowed:

> *With 2+1 students they were coming with very potted knowledge… very gappy knowledge... the NHS… it comes with lots of quirks and if you're familiar with it that's half the battle erm… so it was… daunting in so much as we'd got to catch that up first and then turn this person into a health visitor… that gap towards the end of the placements had narrowed.*

She described mentoring the 2+1 student as daunting: as a new mentor with only three years' HV experience, she can be seen to have limited capital to draw upon, yet she found herself trying to build skills which prior to the HVIP students would have already established. She reflected upon how advanced communication skills and advocacy for vulnerable clients had to be built before she could consider introducing specialist skills and knowledge:

> *That was tricky because… experienced health professionals come with those skills… like managing a diary, they haven't run a ward, they haven't had chance to be an advocate for patients because they've been a perpetual student… a lot of the skills of the health visitor is being patient advocates, able to interface with other professionals of seniority… that comes with… years of experience managing caseloads and running wards and being certainly qualified…*

Natalie reflected upon how her student found the 2+1 programme difficult at times. Natalie identified with the student as she related their experience to her own as a

student midwife. As a direct entry midwife, she was perceived as lacking credentials, viewed as having less cultural capital than the dual trained midwife, and as a consequence of this inheritance she felt this affected her personal sense of accomplishment:

> *It's similar to being a direct entry midwife… you weren't liked… there were the older calibre of midwife that erm… you've not been a nurse? You're not run a ward? Well how can you be a direct entry midwife? And that's stuck… no matter how accomplished you became as a midwife, you hadn't been a nurse first and that was a barrier.*

Natalie described how she enjoyed teaching despite the difficulties encountered and if the opportunity arose she would like to become a PT. However, it had been a tough two years resulting in her taking a period of time off, and this was compounded by a feeling that it was unlikely she would get the opportunity to become a PT with the associated economic capital: *"I wasn't burnt out but had it continued, I would have got burnt out… there's been no meeting to say thank you very much."* For the mentors, the HVIP – although welcomed as an opportunity – was unlikely to convert into the recognition and career progression they hoped for; their narratives depict a degree of disappointment that, despite developing the desired cultural capital, they failed to be rewarded for their efforts. As Bourdieu considers: "The job market reneges on the promises and guarantees made by the educational system leading to disappointment" (Bourdieu et al, 1999, p.507). Natalie concurs:

> *You'd be asked to do it on a band six… it's a dilemma… career-wise I'd be looking to improve myself, with that comes the correct remuneration… I don't want to make life any harder than it already is… I'd be torn… I enjoy teaching students… I do have career progression in mind… I feel as though I'd be helping the Trust out… I did last time and then was dumped (laughs).*

Gemma

Table 14: Gemma's demographic information

Name	Age	Gender	Mentorship experiences
Gemma	55	Female	PT: 10 years' experience as a PT

Gemma's narrative

Gemma had been a HV for 16 years. She was a PT in school nursing before undertaking HV training. She described being well supported by a long arm PT when training to become a PT herself, and this combined with many years' nursing experience has given her a strong sense of habitus and accumulated cultural capital. She described the PT role as involving numerous aspects, teaching, nurturing,

supporting and assessing, as well as looking at individual learning needs. Gemma had long armed at a distance and within the same office, and she preferred to mentor in close proximity as this aided assessment processes as she was able to observe student interactions: *"It's easier, you can actually hear conversations, you can see how somebody interacts with other members of the team, easier to observe day-to-day working really, so it's better."* Outside the office she felt more reliant on the mentor's observations which did not feel as in-depth: *"You're… relying on the long-arm mentor to tell you, which is fine but it's not as erm… rich maybe."* Long arm mentorship (LAM) outside the office involved travelling which was time consuming, although once there she was able to concentrate, whereas in the office she was used as a resource constantly. Clearly, the cultural capital she held was valued in the team, which she sees in positive terms as welcoming her contribution:

> *Team leaders always expect a little bit more, don't they, and to be honest I think that's as it should be. I think we have got a role to play, not just supporting the students, I think we've got a role about leading practice.*

Knowing the mentor as a work colleague also aided LAM. She, like the mentors interviewed, described how sharing the same work environment was significant, and how mentorship was an extension to an already established relationship where rules and positions were already understood:

> *We do get on well and practise in a similar way, we've got… similar thoughts and feelings, we know each other very well, we know how we work. She knew what I would expect from her, she could come to me on a daily basis.*

Gemma's narrative depicts the added complexity of LAM, describing how she oversaw students' learning and competency attainment whilst also assessing and supporting mentors as they learned their role. On occasion when student and mentor disagreed she took on the role of arbiter, all of which was in addition to her caseload and own student:

> *It is a responsibility to long-arm mentor, to know that the mentor is doing what is required... you need to listen… you need to debrief them about their experience… as well as looking after the student… sometimes where the student and the mentor don't see things quite the same… you're trying to look at all sides and really that's quite difficult.*

Complexity also increased as the number of students requiring long arming increased. Gemma presented as a quietly resilient person, able to contain the demands placed upon her; however, she admitted to feeling very tired at times. She described considering the needs of many individuals, which included ways of

learning, previous experiences and progress, remarking that the social world she found herself in had changed and become multi-faceted and complicated:

> *When I've been long-arm mentoring I've had my own student as well, that's thinking for five people, looking after myself, looking after my student, making sure that the mentor is supported, supporting her student, that's a lot of people to think about, exhausting, mentally you're just tired of having to do all that thinking… when it goes well it's great, but when it's not going well then that is really difficult.*

In Bourdieusian terms, Gemma's narrative is one of personal difficulty and subjective tension which articulates the deep structures of the social world (Bourdieu, 2004). Mentoring 2+1 students added to the already complex task of LAM. Gemma described how she preferred to mentor the student herself so that she understood their learning needs. LAM resulted in her being removed from the student, leading to her being reliant on a mentor with less experience establishing the student's learning needs. With one-to-one models there was a closer relationship which meant she could explore the student's habitus:

> *Your own 2+1 student, you see them from the beginning, it's more intensive, you can be aware of their strengths and what they need… when long-arm mentoring you're relying on somebody else to have those discussions… they're new to this role and they need… consistency, they need one person who understands where they're coming from and what skills they bring and… limitations, it's a closer relationship, when you're long-arm mentoring there's a middle man… you're sort of slightly more removed.*

Her use of the term middle man implies someone between her and the student, an intermediary who she saw as a physical barrier to the relationship. In Bourdieusian terms, the HVIP can be seen to have introduced another player in the field, displacing her position; and whilst she respected the mentors as individuals, their position was an impediment to her game. Gemma also felt LAM impacted upon assessment processes, and was concerned that students may feel doubly assessed and stressed because assessment was less discreet:

> *With long-arm mentoring sometimes the students can feel like they're being doubly assessed, even though you say… that's not the case, it still feels that way because they don't know you so well… when assessing my own students some of the time it's discreet, they wouldn't be aware that this is an assessment, but when you work with somebody who you don't normally work with they immediately see it as different, there was a nervousness…*

This was problematic as she felt that she was the one assessing the student, rather than the mentor. She acknowledged the mentor was part of the process, but as the sign-off PT she needed to see their practice first hand:

> *…me as a practice teacher, whoever signs to say that they're fit to be a health visitor, they (mentors) can feed in… and as a practice teacher I'd very much listen to their opinion and value their opinion… it was my responsibility… I want to work with that student… I want to see… it's fine to listen to… the mentor but I need to know it myself, I need to have seen some of that.*

Gemma felt that whilst there were differences between experienced nurses and 2+1 students, there were also differences between many students, all entering with individual habitus and forms of capital. She expected that there would be differences and deficits to be addressed, the 2+1 student journey to take longer, and that she would need to build their competence, in particular supporting them to make the transition from student nurse to qualified nurse:

> *I can't generalise because I've had a 2+1 student who came with many transferable skills and I've had other students who were nurses but had to teach some… skills… when I started I thought that they'll not be… as good as students who've done nursing, that was my pre-judged opinion… I've been proven wrong on some occasions… the first bit is harder because you've got more to teach and you can't get through the… teaching as quickly, you can't get through to the actual health visitory bits that you need to do… as quickly.*

Gemma felt this also impacted upon the consolidation period as she felt the 2+1 students were still learning, rather than consolidating skills already learned. She was still building habitus and capital with them, and as such it was important that they stayed with her:

> *They're still learning… you're still teaching, you know, there are bits that we haven't completed… I'm not sure about moving to a different practice… it'd make it really difficult, very problematic, at the end… you are saying that this person is fit to practise…you need to be really clear that that is the case and confident in yourself.*

When describing her experience of being a PT she was animated and positive:

> *I've always loved it. I feel quite privileged… watching students… develop… who are now health visitors and I feel really sort of proud… for me the positives outweigh the negatives, they always have, otherwise I wouldn't have carried on, but it's really hard work.*

Gemma's narrative depicts a strong sense of embodied habitus: she is confident in her ability and she felt her experience was respected by the team, especially those who had acted as mentors during the HVIP. She understood that some may think the role was easy; however, she dismissed this, explaining that she did not have to justify her work. There is a sense that she knows she has secured her position within the field, that her habitus built over many years is seen as valuable, and as a result she deserves the economic capital she is awarded:

> *I'm just confident… I have heard you've got a student to do some of your work for you, it doesn't bother me to be honest… I know what I'm doing… I know that I'm earning my band seven, I'm doing a good job… I don't have to justify that to anybody… and I've got people working here, some of them have been mentors, there's a respect for being a practice teacher…*

This developed sense of habitus and the position she occupied in the field enabled her to negotiate what she required to undertake the role. Unlike the mentors, she had a reduced caseload, although this was a reduction in births rather than safeguarding and complex cases: *"I negotiated a reduced caseload… because I couldn't give the student a good placement and all the experience they wanted and manage the level of caseload here which was… high with lots of safeguarding."* Gemma reflected on the HVIP and how it was an opportunity for mentors to train as PTs, although she was concerned that they saw this as career progression which was unlikely to be actualised. The HVIP was a means to an end for her, a response to a particular historical moment in time. However, she had concerns that its legacy could be detrimental in terms of practice education:

> *They see a future… that's been fantastic because it's about career development… the next generation of practice teachers… when people are asked… told they are going to be mentors… that's the bit of the new model that I least like, it was a way to boost the health visiting service but I feel that it's… not taking a step forward anymore… it's adopting those ways and continuing, rather than going back to the practice teacher role. I thought it was a short-term measure.*

Towards the end of the interview, Gemma disclosed she was retiring as she could no longer teach the way she felt appropriate. For her, the structure of the field had changed dramatically, and the dissonance between her embodied habitus and the new doxa of practice can be described as a state of hysteresis – where there is a misalignment between field and habitus (hysteresis is further considered later in this chapter on page 131):

> *I was going to retire within the next few years, the new model has pushed me to make that decision earlier… it's not the way I want to be a PT… I don't feel I can support them, that's why I'm retiring, because I don't want to be a PT using the new models…. It's not how I want to practise, I want to give students the best opportunity, the best learning experience and I don't think it meets the standards that we've had before… so I don't want to carry on in that role.*

Sophie

Table 15: Sophie's demographic information

Name	Age	Gender	Mentorship experience
Sophie	49	Female	PT: 9 years' experience as PT

Sophie's narrative

Sophie had been a HV for 16 years. In contrast to Gemma, the catalyst for becoming a PT was a poor experience when training, which resulted in a determination that students would have a better experience with her. Sophie felt her employing Trust prepared mentors well; this was also echoed by Amanda, which differs from the findings of previous research (Morton, 2013). She felt the HVIP had strengthened the way mentors were prepared as the long arm PT acted as a support mechanism: "*I wasn't really prepared for the job, not as much as the mentors have been prepared, they've had that safety net… I didn't have that."* She described her role as multi-faceted, taking into account professional socialisation as well as competency attainment: *"I plan the learning environment, I do action plans… I ensure that they don't just meet learning outcomes, that they develop professionalism… that they are safe."*When Sophie spoke about students she became animated, describing how PTs developed bespoke person centred learning tailored to each student's unique habitus:

> *We know how to get the best out of this person, we don't rush… we develop their skills, we know that they're good at this… but they might not be good at that… we fit it together… think a lot of people are very judgemental of students and expect a lot… don't put themselves in the student's shoes, I think we do…*

Whilst describing that students are expected to take an active role in their learning, her narrative is one of nurture and support. Seeing herself as an advocate for all learners, she intimated that the habitus of the student was vulnerable to exploitation, requiring protection and space to learn in a complex health field. PTs were described as offering a high level of support, which recognised and upheld students' supernumerary status, ensuring learning opportunities were appropriate and frequent which she felt was appreciated by students:

> *Students say it's a different experience with the PT… we look after them… we're… fighting their corner… there's a kind of a… pastoral role, we're not… spoon feeding them but we know where they're coming from… it's about safeguarding the supernumerary status, they aren't a pair of hands, they need to have time, any student not just SCPHN, I'll speak up for pre-reg students if I see something happening and say you've had them filing, why?*

Sophie, in common with Gemma, presented as having a strong sense of embodied capital: she was proud of the job she did, considering PTs to routinely go above and beyond their role. Her narrative placed the student at the centre of learning and suggested she viewed her role as an altruistic endeavour. Speaking in vocational terms, she considered the personal relationships she had with students to be a unique experience which she valued greatly:

> *It's not just a job, PTs go above and beyond, we are responsible for the student, I do think the mentors are excellent but I do think you need a student day in, day out, year in, year out to hone those skills and to be confident with students… to live it and breathe it, others think, oh they're a student, and never get to know them, whereas we do and they never have that unique experience of that tight relationship of that one-to-one in the car, talking.*

In keeping with Gemma she felt it was harder to support the 2+1 student, particularly during the first semester. She described how the students acted as though the HV element of the 2+1 programme was an extension of pre-registration training; when viewed through the lens of Bourdieu, their habitus was still that of a student nurse as they had not internalised they were now qualified and accountable to the NMC. She described helping students to transition into the role of qualified nurse as well as that of a SCPHN:

> *The 2+1 see themselves on a student nurse course… until about December… when… you talk about accountability, that they're a registered nurse, you can see the fear in their eyes. I've also had to do something that I've never had to do… 'pull them up', challenge them about things like mobile phones, professionalism, timekeeping… you're trying to get a student up and running within a one-year programme, the first three months is so heavy… it's hard to get their minds set to I'm actually training to be a specialist practitioner… it blows their mind a little bit.*

Sophie recognised the 2+1 students all had previous knowledge and skills which she valued; however, she remained concerned that they had not practised as qualified nurses and in particular had not worked in multi-professional teams, or made judgements in challenging and complex situations:

> *Taking a 2+1 student is harder, it worries me that they haven't got some of the background experience of working… I'm not saying that they haven't got experience, but they haven't got experience of working in a very integrated manner with a lot of very challenging health professionals and situations, I think the course should have been longer for the two plus ones.*

She also had concerns regarding the accelerated programme, feeling the nature of health visiting had become more intensive, which is mirrored in many early intervention documents discussed in chapter one. Despite this, she had to facilitate the inexperienced 2+1 students' level of competency within the same time frame as the experienced students: *"It's intensive what we've got to do now. Health visiting's getting more stressful, there's more in it now, there's more to do."* Moving students in consolidation made mentoring more difficult and she felt students should stay in their original placement, and furthermore felt the Trust did not listen to her, failing to recognise the immense capital she draws upon to make this conclusion:

> *They're still getting to grips with universal assessments, rather than being where they should be, taking a caseload, it takes the student two to three weeks when they're moved to get in to that new base and it sets them back… trying to assess somebody who's had forty weeks in another area is difficult. I have a real big issue about moving students in the consolidated period, it doesn't matter how much I say it's detrimental to students, they're going in to new caseloads and… they've only got ten weeks to build up therapeutic relationships.*

Like Gemma she was complimentary about the mentors she supported, describing a relationship aided by close proximity. Sophie described how one of the mentors was previously her HV student and this was thought to be beneficial as they practised in the same way, sharing habitus and doxa: *"I actually trained my mentor, she was my student, so we actually think the same."* This comment by Sophie can be seen to confirm Bourdieu's observation that the field of education reproduces itself more than other fields with those players in dominant positions being deeply imbued with its practices and discourses (Grenfell, 2012). In the same way as Natalie and Gemma the legacy continued, demonstrating the significance of the PTs position in terms of reproduction. Sophie did describe the difficulties which arose when there were concerns, such as the mentor not raising or dealing with issues in a timeframe she felt acceptable: "*You're seen as the bad guy pulling them up. I think they do feel a little bit, you know, I'm not getting paid a band seven… but they have to act, I can't… do something if they're not in my base."*

The HVIP has heralded changes which appear to have impacted upon Sophie significantly, as she described feeling tired and unable to do everything expected of her: *"It's massive, it's become massive."* Unlike Gemma, she described how she had no reduction in caseload and how this had at times rendered her in tears. Being paid at band seven was seen as a mixed blessing, as with the grade came unmanageable expectations and the resulting strain left her feeling stressed. Through a Bourdieusian lens, the PT grade is viewed not as valuing extensive cultural capital, but rather as a reason to work harder and harder:

> *They expect me to work faster, harder, smarter, take on a full caseload and a student because I'm a band seven, everything's an add-on… I have been hammered this year, absolutely hammered and I'm hammered every year… any difficult students they're placed with me… anyone who'll be a little bit more challenging, they've put with me… I have to get to a point and nearly be tearful, and then say I can't do it, I'm really stressed… and then they say ooh, OK… but they haven't taken anything off me. I'm doing everything…*

Since the HVIP, she felt her emotional health had deteriorated as she tried to fulfil her caseload responsibilities and manage students and mentors. Like the other educators interviewed, her work-life balance was affected as she took work home in a bid to

complete everything. Worrying about making a mistake, she felt she was at the point of reaching burnout:

> *My own mental health suffers… it's day in day out, Monday to Thursday my life stops. That has a knock-on effect with your family, I love it so much but… but I'm gonna burn out. I'm going to burn out or make a mistake and I don't wanna end my career having an NMC enquiry and somebody saying oh you're too busy you should have told us… I raise it at my appraisals all the time and sometimes I think it would take me to go off with stress…*

In Bourdieusian terms, Gemma and Sophie can be seen to be expressing suffering as they became poorly adjusted to the changing conditions of HV practice education. Bourdieu views the everyday world as a place of conflict, where there are tensions, discrimination and contradictions, and where new forms of suffering occur as a consequence (Bourdieu, 1984). Like Gemma, Sophie's habitus seemed to no longer fit with the new order and she struggled to accept that long arm mentoring may be her future. She frequently used the word "worry" to describe her responsibilities, stating she did not want to continue as a long arm mentor:

> *I would love to have a one-on-one student back… I don't mind having two students but I do not want to long-arm. I don't want the worry of the mentor, I have a worry of a mentor, a worry of a student and then the team leader in another base… I just want the student with me, I just want it to go back to how it was, one-on-one, and if it does that I'll stay a PT till I retire… I love my job but it's getting so difficult to do... if I can't do it how I want to do it I'd rather not do it.*

Sophie had considered leaving practice teaching. Reflecting upon the Trust's response she was pragmatic when discussing their reaction, feeling they would be unconcerned about losing her expertise as mentors would undertake the role on a lower grade. Mentors, she felt, were willing to do this as they saw the mentor role as the gateway to promotion. Sophie did, however, feel valued by the university:

> *They'd say fine, if you don't want to do the job we'll get someone on a band six to do it… nobody comes up and says you've done a really good job this year. Nobody, except yourselves, I love the university, I love the fact that the university always says how valuable we are, cos we don't feel valued.*

Sophie reflected upon the changing nature of the PT role: too young to retire, she thought of transitioning into an educational role. She considered that this would be a loss to the practice area as she would take many years of experience with her. Said with humour, she called for a conservation programme to protect PTs. However, the message she was sending was serious – if PTs decide not to continue, this would leave a gap in HV practice education that Trusts and universities would notice:

I have thought about leaving practice teaching… I've really thought about it… if they lose me they lose all my experience… I'm quite happy to go somewhere… and be a lecturer, one of our health visitors just left to do that, I do think that PT breeding needs to be kept alive, we gonna be made extinct, we need a conservation programme… you'll miss us when we've gone (laughs).

The eight individual narratives have been presented as stories in the whole, which is congruent with the IPA tradition of an idiographic approach and Bourdieu's approach to analysis which allows the reader to draw additional conclusions from the data. The following section summarises each individual narrative.

The summaries

Nadia's summary

Nadia described a challenging learning journey which was impacted upon by structural changes within the field, numerous moves during her placement, and comparisons between 2+1 students and traditional students which affected her sense of self and developing habitus. Her PT was seen as supportive, socialising her into the doxa of practice; however, she articulated how difficult the transition had been from her previous role as CNN to that of student HV. Paradoxically, cultural capital accumulated over many years carried expectations with it; this was seen at times to impede rather than enhance her learning journey, as she strove to leave her old self behind and gain a new position within the field.

Abigail's summary

Abigail's experiences can be seen to have shaped her evolving habitus as both a nurse and soon to be qualified HV. As one of only two mental health nurses on the 2+1 programme, she questioned her sense of cultural capital in comparison to students from other nursing fields. Her PT is described as developing a bespoke learning package which acknowledged her habitus and ultimately ensured she felt suitably prepared for practice as a HV; however, she failed to recognise herself as a nurse. In common with other student narratives, she expressed a human need to belong and this is articulated by her decision to stay in the practice placement area when her PT was absent. At the time this was seen as preferable to negotiating her position within a different practice area, although ultimately she recognises this may have affected her learning.

Veronica's summary

Veronica's HV placement was regarded in positive terms, despite mentor absence and structural changes in the field including team mergers and changing bases. She

described a close supportive and protective relationship with her PT, which facilitated her sense of competence, habitus and cultural capital. Her identity as a 2+1 student was viewed as problematic: she recalled encountering negative comments concerning the accelerated route, and this was particularly difficult during pre-registration placements where she felt mentorship was less in-depth. Presenting as a quietly spoken but determined character, she admitted to not disclosing that she was a 2+1 student during her nurse training; this became a time of hidden identity where her habitus was disguised in order to protect her position within the field.

Helen's summary

Helen's narrative described her experience as an emotional rollercoaster. She related a challenging journey which was a very steep learning curve. In common with the other three students, she experienced mentor and placement changes which left her feeling cast aside and an outsider at times. Despite these difficult times, she recognised she had excellent mentorship which was supportive and ultimately transformational. She, too, experienced negative comments in her nurse training regarding the 2+1 programme; conversely, her habitus was embraced by the PT who considered the cultural capital acquired outside nursing to be as significant and valuable as nursing experience. Staying with the PT allowed her to blossom in the consolidated period.

Amanda's summary

Amanda described how the HVIP was the catalyst for becoming a mentor: considering her cultural capital was relevant, she seized the opportunity. She described enjoying the role and felt the long arm mentoring process worked best when she and the PT were co-located as a sense of shared habitus aided their relationship. Her narrative is also one of pressure and stress: inexperienced 2+1 students and changes in the field impacted upon her work-life balance, and she felt the work of the mentor was undervalued and unrecognised. Amanda described the mentor role as having less capital than the PT role, and aspired to be recognised as a PT once she attained sign-off status; however, she was sceptical this opportunity would arise.

Natalie's summary

Long arm mentorship worked well for Natalie as she and her long arm PT were co-located. She described how she and her PT were also placed with the same PT when training, and this form of cultural reproduction was an enabling factor which she described as a legacy. Natalie spoke of significant pressures caused by fiscal

constraints and the HVIP, with the resultant inexperienced students placed in a demanding clinical area. With no reduction in caseload, she described feeling overwhelmed and heading for burnout. Natalie felt the cultural capital developed by mentors went largely unrecognised by the Trust; and despite attaining stage three sign-off status, as the HVIP came to an end she had come to the conclusion that she was unlikely to attain a PT position. This left her feeling disregarded and undervalued.

Gemma's summary

Gemma's narrative is one of subjective tension. She described loving her role as a PT and as a dual trained school nurse and health visitor, and she possesses a wealth of accumulated cultural capital. As a result of the HVIP, she felt long arm models have resulted in the social world of practice education becoming more complex and demanding. She felt new models were less effective and admitted to missing the close proximity of the one-to-one model. She felt that long arm models thought to be an interim measure were in fact being adopted permanently, and as a result she had ultimately hastened her plan to retire. The dissonance between her sense of habitus and the new social context she found herself in was too great, resulting in her no longer realising her embodied sense of autonomy.

Sophie's summary

Sophie described her passion for teaching students, and like Gemma had a wealth of cultural capital to share and pass on to the next generation of HVs. She described the multi-faceted role of the PT, emphasising both competency attainment and the significance of advocacy and nurture. The HVIP and the introduction of long arm models of practice education were described as changing the nature of her role considerably; this affected her health and ability to be the teacher she wanted to be. Enacting the PT role caused conflict and tension for Sophie with new forms of suffering occurring as a consequence. Unable to reconcile herself to the role of long arm PT, she considered a career change believing PTs would become a scarce commodity in the future, with the resultant loss of social and cultural capital built over many years.

The narratives exemplify the key issues experienced by the participants within the social context of current HV practice education. As a result of the HVIP, new models of education and widening access to health visitor education, there would appear to be substantial dissonance as the participants described the constraints and difficulties experienced when enacting their roles. The following section will consider the common themes derived from the narratives in relation to field, capital and habitus.

Emergent themes

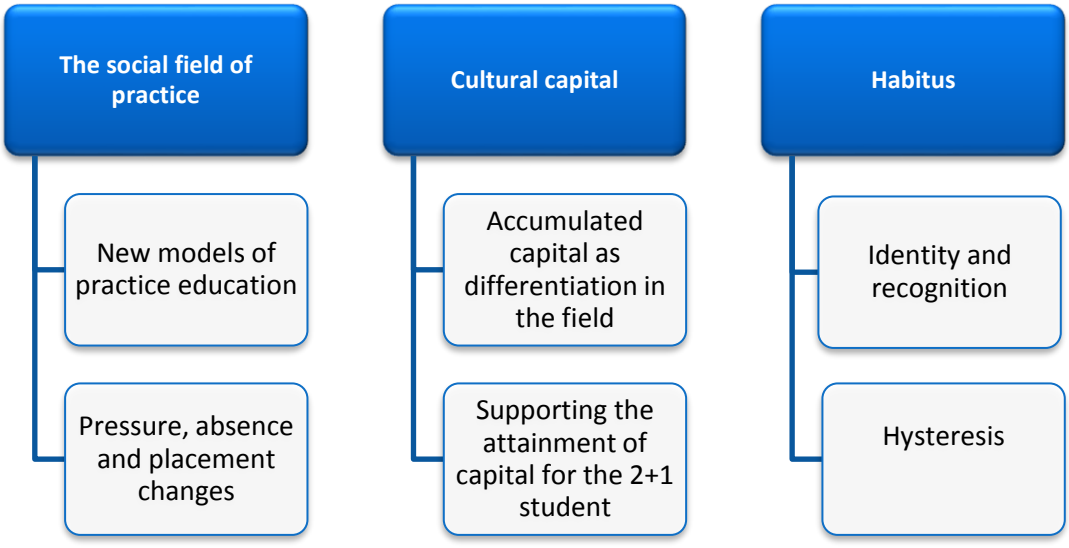
Having considered the individual narratives, the data was explored further to develop commonalities. The emergent themes were documented and clustered to show patterns and connections. This process enabled the data to be organised into superordinate themes for each participant and for themes shared across cases; this was repeated for all eight transcripts. On completion three superordinate themes were identified operationalising Bourdieu's theoretical constructs as they recurred within and across the participant interview transcripts. These are presented in table 16.

Table 16: Superordinate themes

Superordinate theme, present in over half of the sample (J. A. Smith et al., 2009)	S1	S2	S3	S4	M1	M2	PT1	PT2
Changes within the field of practice	✓	✓	✓	✓	✓	✓	✓	✓
Cultural capital	✓	✓	✓	✓	✓	✓	✓	✓
Habitus	✓	✓	✓	✓	✓	✓	✓	✓

Each superordinate theme is deconstructed into accompanying subordinate themes including direct quotations from the participants.

Figure 6: Superordinate and subordinate themes



According to Garratt (2013), data interpretation cannot stand outside the influence of social and political contexts. The findings will therefore be considered in the context of the historical and political climate in which the research took place. Bourdieu's inter-related theoretical constructs are drawn upon to frame the analysis and discussion and enrich the thematic exploration of the participants' experiences.

The social field of practice

The HVIP can be viewed as a particular historical period in the social field of health visiting. Social fields change over time including the way practice is produced and reproduced, and as a consequence social agents are controlled by the structural forces which orientate social practice (Grenfell, 2012). As a result of the HVIP, the social space occupied by the participants underwent significant structural changes: the political agenda was enacted through the HVIP, and changes to the unique internal rules which operated prior to it fundamentally changed predetermined positions. Existing roles were challenged along with social connections, relationships and the way educational processes were enacted.

New models of practice education

The literature search revealed that the increase in student HV numbers had placed record amounts of pressure upon PTs to manage the practice education of a greater number of students (Bayliss-Pratt, 2015), and the findings from this current study corroborate this view, depicting the players bound by the constraints of the historical period. Widening access to recruitment resulted in increased student numbers and, as was the case with the 2+1 students, students with less experience, resulting in fundamental changes to how students were supported in practice. When viewed through a Bourdieusian lens, the PT/mentors whilst recognising the students held cultural capital gained outside the NHS realised that they had not had chance to develop cultural capital and habitus as a qualified nurse. Natalie illustrates this point, describing how she found that students who had worked as qualified nurses had acquired cultural and social capital in the form of advocacy and communication skills: "…*able to interface with other professionals of seniority… that comes with years of experience managing caseloads and running wards and certainly being qualified"*. Natalie would seem to be describing a particular type of capital which can only be accumulated as a qualified nurse working in the specific field of the NHS with its own unique doxa of practice.

The literature review highlighted the HVIP had resulted in a shift in focus from one-to-one mentorship models to LAM models (Bayliss-Pratt, 2015; Devlin et al., 2014; DH, 2011c). The study findings corroborate this view, with the PTs reporting they supported up to three students and mentors resulting in sign-off responsibility without the day-to-day contact associated with the one-to-one model. The peripatetic 'roving model' discussed by Devlin and Mitcheson (2013) was not in evidence, although the PTs did report sometimes supporting mentors and students across wide geographical

areas. LAM facilitated at distance was not viewed positively as mentors felt unsupported and PTs considered distance affected their ability to determine the needs of the student and the mentor. When students, PTs and mentors were co-located this was described as aiding the mentorship process; the data, however, suggests this was more than the consequence of close proximity. Co-location was significant in terms of the PTs, mentors and students all inhabiting the same social field as this resulted in them coexisting as players, sharing and understanding the unique set of rules within that field. Hilgers and Mangez (2015) state cultural life and its production are field situated and within each given field there are specific rules; the findings suggest the players understood how to act and behave within the micro field of their practice area, the positions of the players were established and accepted, and they were all familiar with the client caseload, team structure and the students' position within the field. As Amanda stated: "*When (Name) was in the base… I think it was much easier for her to have a relationship with the student… being in the same base that made it slightly easier."* Equally, Gemma felt not being co-located was problematic for her as a PT: "*You don't know how they work in multi-disciplinary teams… you don't know how they delegate work.*"

When co-located, the students reported feeling comfortable working alongside the PT and mentor as they had an established relationship with both players; as Veronica stated, "*It's easier to just catch someone and ask them things if they are in the same base as you and… I think they get a better idea of who you are as a, you know as a practitioner."* For Veronica, LAM within the same social field meant she was observed every day by players she knew; this, she felt, aided the PT's assessment of her as she could see her practice and observe evolving habitus. When operated at a distance, LAM heightened the sign-off concerns of the PTs as they felt removed from the mentor and student, and this was complicated further by additional players in other social fields such as team leaders who all managed their teams slightly differently. Mentors felt unsupported when based away from PTs, and PTs deemed the distance affected their ability to determine the needs of the student and mentor. The significance of the PT being accessible and able to support mentors is pertinent, as the literature review highlighted that many SCPHN mentors felt pressured into roles they were ill prepared for (Morton, 2013). In this study the mentors reported they felt well supported by the PT, but less so by their teams, team leaders and managers. This makes long arm support crucial as mentors establish their position within the field, and this support would appear to be aided by co-location. This is a finding which has resonance in relation to the new NMC standards (2018b): as mentorship moves

forward, students will be supported and assessed by a day-to-day supervisor and an assessor. Where assessors are located and how they will support students and mentors need to be considered, as distance would seem to impact upon practice education.

Prior to the HVIP, the extant literature points to an association between high workload demands and role dissatisfaction (Carr & Gidman, 2012; Haydock et al., 2011). PTs were feeling under pressure when engaged in a one-to-one model of education, resulting in the exhibition of moderate degrees of emotional exhaustion, with the potential for burnout (Haydock et al., 2011). This thesis extends the work of Morton (2013), Sprinks (2013), Devlin et al. (2014), Carr and Gidman (2012), Haydock et al. (2011) and Deave et al. (2017), demonstrating that changes within the field have heralded additional pressures as PTs and mentors continue to struggle with workload pressure alongside increased numbers of students and supporting more than one student at a time, as illustrated by Natalie's feelings of "being awash". Findings suggest the recommendations made in previous studies to reduce the felt pressures of mentorship such as protected time, reduced caseloads, and increased peer supervision and support appear to have been implemented inconsistently (Carr & Gidman, 2012; Haydock et al., 2011). The participant narratives depict PTs and mentors working hard to maintain quality practice placements, and students were positive about the calibre of support they received. However, the findings suggest changes to the structure of the field of practice have added to the complexity of practice placements, altering the relative positions of the players (Hilgers & Mangez, 2015) and making mentorship more difficult to enact. Amanda's narrative illustrated this when she spoke of the difficulties encountered when new to supporting 2+1 students and LAM. This resulted in expectations of the students that were unrealistic given the students' degree of cultural capital. This finding is significant when considered in terms of the changes to mentorship processes to be introduced as a result of the new NMC standards (2018b). Resultant changes will include key players experiencing new processes and learning new rules whilst working in high pressure and busy clinical environments. This has the potential to increase workload pressures for supervisors and assessors, particularly when embedding new models of practice education.

Pressure: Absence and placement changes

The extant literature points to the demands placed upon PTs and mentors (Carr & Gidman, 2012; Haydock et al., 2011; Morton, 2013), including frequently working over

contracted hours and feeling under pressure when trying to balance the clinician, educator and LAM aspects of their role. This thesis extends previous findings, highlighting the additional pressures felt by PTs and mentors when working in inexperienced teams. The HVIP can be seen to not only have changed the educational structure of practice placements, but also the structure of the profession itself and the social field in which practice is enacted. Habitus formation and the acquisition of capital are developmental (Bourdieu, 1986), and within the social field at the time of the study many of the newly qualified HVs were still acquiring social capital and needing additional support themselves. This resulted in newly qualified HVs being unable to manage complex cases, leaving the experienced mentors and PTs managing these cases as well as trying to support students. Mentors in particular found this difficult, as they lacked the accumulated capital of the PTs with regards to the dual role of clinician and educator. In keeping with K. Adams (2013), the levels of pressure experienced by PTs and mentors did not go unnoticed by students who commented on their struggle to manage clinical and educational demands:

> *There was a period of time that she had to be away from work because of stress.* (Abigail)
>
> *She came over and apologised and said… I've realised actually I can't do both.* (Helen)
>
> *We weren't sure how long she was going to be off for.* (Veronica)

The findings show that all four students experienced changes within the social field, and were impacted upon by PT/mentor sickness or absence or a breakdown in placement. Students recognised that their PT/mentor tried to protect them from clinical pressures, but when placements broke down and relationships were interrupted this affected the participants adversely. Three of the four students stated they felt insecure when they had to move and the third student elected to stay in a placement without a day-to-day mentor, such was the significance of maintaining her position within a social field in which she felt comfortable. Moving in the consolidation period was seen as particularly challenging for all of the students, as they were still acquiring social capital and needed support from the educator they knew. From a Bourdieusian perspective, the social field of practice education is part of an ongoing construction and changing placements, particularly in the consolidation period, caused a hiatus in this construction which affected the students' sense of security and the perceived support they received. The stress of moving during this time was summed up by Nadia: *"I don't feel as secure… I feel like I'm still a student and I'm still learning and I know I'm at the end but you know, I don't feel like looked after as such."*

The social field can be seen to be a fluid space, which was affected by structural changes and the systems of relations within the field; this in turn affected the experience of all the players. Hilgers and Mangez (2015) describe the history of the field as the history of internal and external struggle and the distribution and variation of capital. The concept of capital and how this delineated the players will be considered next.

Cultural capital

Accumulated capital as differentiation

Bourdieu's concept of capital can be used to consider differentiation within the field of practice education, and in particular how the recognition and reproduction of culture affected the participants (Grenfell, 2012). Bourdieu's categories of capital – cultural, economic, social and symbolic – were all seen at play within the participant narratives. Accumulated capital acted as part of the structuring process of habitus for all of the participants (Bourdieu, 1984). Cultural capital built over time positioned the PTs within the field: they had built a reserve of capital over many years as they interacted with students and stakeholders in the practice placement environment (Grenfell, 2012). The PT was awarded the title of teacher, a form of symbolic capital which elevated the position of PT over that of the mentor. Their capital was recognised by the Trust and as a consequence their position was seen as part of the structuring process of practice. Within the field the players' positions were unequal and the PTs can be seen to be dominant, even though the structuring force of the field had changed the way placements were facilitated and how they enacted their role. The PTs were viewed as key players driving the educational process, which culminated in summative sign-off. Summative sign-off reinforced the position of the PT as they oversaw the attainment of NMC competence; this symbolic act denoted the accumulated capital of the PT as superior to that of the mentor, and this was recognised and acknowledged by the students. The students described how the PT had acquired capital over many years, how they had internalised the traditions of practice education, and ultimately the students understood the PT was the person signing-off competency with the NMC. This was seen to give the PT a social advantage and higher position within the social field. Sign-off status functioned as a form of cultural capital, which bestowed distinction and power over assessment processes. As the sign-off assessor, the PTs acted as regulators overseeing the mentor's work with students; using their position as dominant players, they determined what was legitimate learning and what educational practices were appropriate. The data therefore depicts mentors as disadvantaged as the PTs used accumulated social

capital to position themselves within the field. The students placed with mentors appeared to view the PT as the genuine assessor, even though they recognised the mentor also assessed them. This is illustrated by Nadia and Helen, demonstrating both mentor and student were subjected to and conformed to the influence of the PT:

> *I feel that the practice teacher is more… authoritative… I felt she… felt like a teacher, not… authoritative like in a negative way [an] official gives you a date, I mean I want you to do this by next week… with her I felt like it was more of a formal chat. Whereas when I met with my mentor it was more informal.* (Nadia)

> *I kind of saw PT more as she knew the programme, she knew what needed to be done in order to get me through that programme, she would check up on me, she would keep me… on track really… whereas mentor and I our relationship was… I need to do this, can we do this together.* (Helen)

Drawing on Bourdieu's lens of symbolic capital, the PTs were remunerated for their role as educators and this gave them elevated status and symbolically more power than the mentors. Symbolic power relations can be viewed as being directly linked to a hierarchy of capital and the narratives present how the PTs, mentors and students all grappled to gain, contain and retain control as they experienced power relations. All forms of capital are beneficial as cultural capital transforms assets into social advantage (Moore, 2012); however, economic capital carries more status than other forms of capital, crucially reinforcing the position of the PTs within the field. Their accumulated social, symbolic and economic capital were all recognised, becoming embodied and part of the respected shared doxa of the field, that which is taken for granted. This in turn affected the way the players and other stakeholders ascribed legitimacy to the PT and their position within the field. Power relations can therefore be seen to shape the experiences of all the players. The data does, however, demonstrate that the PTs and students recognised that the mentors also possessed cultural capital. The PTs and students were complimentary when discussing the mentors' contribution to the teaching and learning process, and students recognised that sometimes they were subjected to more learning opportunities because of the exposure to two practitioners with differing capital and habitus. This finding is in keeping with Deave et al. (2017), who also found that students appreciated the opportunities which arose from being placed with two educators.

Unlike the PTs, the mentors were not remunerated for their role and their narrative suggests it unlikely this would change despite having attained stage three sign-off status. The mentors described a situation where having played by the rules of the game and accumulated social, cultural, and symbolic capital in the same way as the PTs did before them, they were unlikely to be financially rewarded with the position

of PT. This situation was also recognised by the PTs, who both expressed concerns with regards to career progression for mentors:

> *They're doing it because they want to do it and because they see a future… for themselves to be a practice teacher… it's about career development.* (Gemma)

> *They see it as dead man's shoes… and I think the rest of the staff have felt like, well, you've taken it on a band six… when we've gone as band sevens they might not replace us.* (Sophie)

As the HVIP came to a close, the capital the mentors had attained was no longer required, resulting in an inability to assert individual agency and practise as qualified PTs. The structuring force of the field can therefore be viewed as denying the mentors the opportunity to maximise accumulated capital as the adoption of market forces eroded the recognition of the mentors' habitus, and as a result the bestowing of economic and symbolic capital they had worked hard to achieve (Brown & Szeman, 2000). All of the educators questioned the future of the mentor role, cognisant that the mentor would not be given the same standing as the PTs despite attaining the same educational level. Although the mentors had invested considerable personal time and effort, they expressed that there was a general lack of recognition for the capital they had acquired. The social space can therefore be viewed as a force pervaded with power struggles which the mentors were powerless to affect. This situation was also recognised by the PTs who voiced concern for the future of the mentor role in health visiting practice education.

The findings suggest the PT/mentors, whilst recognising the students did not have qualified nursing experience, still valued the cultural capital accumulated prior to the students entering the 2+1 programme. The students' capital developed outside nursing was viewed as a strength in the health visiting programme, whereas the students voiced a different experience during the pre-registration element of the programme. The students described how their prior experience was discounted and their 2+1 identity was widely regarded as a disadvantage during pre-registration training. In a bid to fit into the doxa of the field and avoid being stigmatised and judged negatively, some students described how they hid this aspect of their habitus, as Veronica states: *"I suppose even through nursing I'd felt that, so by the time I came in to like my second year, which is the third year, I never told anybody (laughs)… yeah".* This is significant as a nurse's professional identity is connected to the commonality of the nursing profession, which is in turn intrinsically connected to the promotion of the ideals of the profession (Hensel, 2013; Ohlen & Segesten, 1998). This lack of disclosure had implications for the students' educational needs: in not

revealing their 2+1 status, students were assumed to be in their second year of pre-registration nurse training with the associated accumulated capital. As this was not the case, the students described feelings of uncertainty and a lack of confidence which impacted further upon their evolving sense of habitus.

The students also described how seconded students, unlike themselves, were rewarded with objectified capital in the form of laptops and diary covers. Bourdieu (1986) refers to capital in three states, embodied, objectified and institutionalised. Objectified capital refers to material objects that correspond to educational pursuits or the equipment used to signal roles. To those around, these objectified forms of capital signal the position held by the player and the level of cultural capital possessed. This form of capital differentiated the 2+1 students from the seconded students in the field, and they commented on how other students were thought of as employees with more developed social connections, networks and social capital. This combined accumulated capital was viewed by the 2+1 students as giving the seconded student an advantage which ultimately would convert into economic capital, as they were more likely to be offered a HV position on qualifying. Symbolic, social and economic capital can be seen to strengthen the seconded students' position in the field and in turn their sense of evolving habitus (Walther, 2014).

Supporting the attainment of capital for the 2+1 student

The previous section reflected upon cultural capital accumulated as part of a socially constructed process, formed in part through relationships with others. The significance of relationships was a ubiquitous theme for all participants, impacting on participant identity and crucially the facilitation of learning. Congruent with IPA, the participants were encouraged to explore their experiences and it was apparent that personal supportive relationships were viewed as important and pivotal to learning. In order to make the transition from a newly qualified nurse to a HV, the PT/mentors recognised that students needed to be socialised into the profession through educational processes in combination with a supportive relationship (Johnson, Cowin, Wilson, & Young, 2012). The SCPHN PT/mentors were described by the students as having a key role in the development of their cultural capital, and this was achieved through a process of relationship building, role modelling and formal mentorship in the form of assessment and robust action plans as identified in the extant literature (Kelly & Ahern, 2009). Students frequently identified that pre-registration placements were busy and mentorship was less in-depth, reporting spending minimal time with mentors and little or none on action plans, as Helen said:

> *It was just a different experience. It was like… I need you to go and do blood pressures, off you go, I know that in the acute setting it's very different… I'd be sort of saying I'm really sorry but I really need this signing-off and I'm not somebody that badgers people a lot really… you almost feel a nuisance.*

This finding is in keeping with the work of Levett-Jones, Lathlean, Higgins, and McMillan (2009), who found negative learning experiences impacted upon learning, morale, perceptions of nursing and the personal sense of nursing identity.

In contrast, the HV programme was described as structured and nurturing with an emphasis placed on student supernumerary status and bespoke mentorship. This was tailored to individual habitus and the capital already acquired and needing to be attained. In keeping with the extant literature, the students had high expectations of the support they required (Whittaker et al., 2013), and the students emphasised the significance of the relationship between the PT/mentor and themselves. The students in the study espoused a notion of wanting to feel safe: Nadia in particular wanted to be viewed as a student, referring to her PT in childlike terms such as having "*mum skills"* and having "*snatched me up".* This narrative can be viewed as having paternalistic overtones and juxtaposed to adult learning theories; however, the student narratives demonstrate how in valuing the capital held by the PTs, this instilled a feeling of safety which aided their accumulation of habitus and capital. The PT/mentors did voice an expectation that as qualified nurses and adult learners the students should be self-directed and independent learners; however, the PT/mentors recognised the significance of secondary socialisation and their role within this process. The PTs in particular recognised that 2+1 students would take longer to accumulate capital. Bourdieu (1977), primarily referring to education within schools, considers the significance of the structuring force of education; the findings suggest the PT/mentors also considered this in relation to practice education and their role in guiding and supporting:

> Habitus transformed by schooling, itself diversified, in turn underlies the structuring of all subsequent experiences. (Bourdieu, 1977, p.87)

The PT/mentors prioritised a relationship of trust and respect between themselves and the student, taking time to understand the student's learning style, habitus and accumulated capital in order to transition the student into specialist practice (Del Prato, Bankert, Grust, & Joseph, 2011; Jarvis & Gibson, 1997; McInnes, 2013). The participants described a collaborative learning process which can be seen to embody andragogical principles of teaching and learning, encouraging students to work with the PT/mentor which is significant in terms of developing cultural capital. Knowles (1984) refers to the concept of andragogy to describe adult learning, and central to

theories of andragogy is a trusting teacher-student relationship which acknowledges that adult learners are involved in a process of development and growth, bringing with them experience and existing knowledge (Knowles, 1975). The theory of andragogy can be seen to embrace Bourdieu's central constructs of habitus and capital which are pedagogically advantageous to the education journey. Adult learning theory also adopts a constructivist approach, drawing on sociocultural theory. Vygotsky (1978) considers knowledge to be constructed through social interaction which aids cognition. Vygotsky introduced the 'zone of proximal development' (ZPD) (Vygotsky, 1978), which is concerned with development determined through independent problem solving, with the level of potential development determined through problem solving under expert guidance. According to Kozulin, Gindis, Ageyev, and Miller (2003), pedagogical practices are dependent on the ability of teachers to match instruction to the developmental capabilities of students as they scaffold the learning process. Scaffolding of learning was referred to by Helen; as a qualified teacher she identified with this pedagogical concept, explaining that her PT did this with her as she modelled best practice through a gradual step by step approach:

> *It's gradual, because she… gives you baby steps I suppose, she scaffolds it, that's what she does, she scaffolds your learning, yeah and that's what they talk about with little ones, you scaffold the learning and then you let them fly sort of thing.*

Such an approach was also mirrored in the educators' narratives as highlighted by Amanda and Sophie:

> *It's… gradual… sharing experience… you go through the stages where they're observing you, learning on the job… a lot of reflection… a step by step way.* (Amanda)

> *We actually do things slower, give them time to reflect, to talk, we know the programme inside out, we know how to maximise that learning outcome… we're often directing them.* (Sophie)

Students described how they appreciated the time afforded to building relationships with their PT/mentor. Knowing the student's name was deemed significant, as was eye to eye contact, offering drinks, a place to sit, all of which gave value to the individual. A sense of belonging was seen as an important factor, even though the students were qualified nurses when they embarked upon the HV programme, suggesting that the need to belong continues to be important to the development of identity long after training (Walker, Dwyer, Broadbent, Moxham, Sander, & Edwards, 2014; Willetts & Clarke, 2014). In keeping with the extant literature, when the mentorship relationship was interrupted this affected the participants adversely

(McInnes, 2013). Gillespie (2005) considers the student-teacher connection, which provides a space where students are transformed and supported as they achieve personal and professional growth. In Bourdieusian terms, when this connection was severed during placement changes the students felt they had lost their position and the cultural capital they had built within the social field; in a constantly changing context, relationships became fractured which affected belonging, learning, communication and the development of capital.

The findings suggest that for some of the students changing placements was particularly difficult in the consolidation period. Students who stayed in the same placement area such as Helen described a period of great personal growth, using terms such as “blossomed”. Those that were moved reflected on this as a difficult time which affected their learning journey, although they acknowledged the experience of two areas was positive in some respects. The participants all viewed the placement area as a discrete field and being moved affected their personal sense of connection to the social space. Nadia in particular, having experienced numerous changes, demonstrated her disassociation with the new social space in which she found herself; this is concerning as education is primarily concerned with growth and development, and this is aided by active student engagement. For all of the participants, the consolidation period was viewed as a time when cultural capital was still being developed and personal habitus formed. The findings depict the 2+1 students as requiring didactic teaching and socialisation into the profession which took longer than that of other experienced HV students. The consolidation period was seen as a continuation of this process, rather than the student taking responsibility for a caseload. Pedagogically, there is a tension between looking after and supporting students and the need to develop autonomous professionals (Candy, 1991; Scharle & Szabó, 2000). The findings from this study would seem to suggest that the PT/mentors recognised this balancing act, and felt that the consolidation period for this particular group of students called for a period of further support in order to develop competence and autonomy at the point of registration.

Habitus

Bourdieu considers habitus in terms of social identity, disposition and development of the individual, which is part of a socially created process which changes over time (Jenkins, 1992; Navarro, 2006). Habitus, whilst durable and transposable, is also evolving and interrelated with the field (Bourdieu, 1993; Maton, 2008). Through Bourdieu’s lens of habitus, the unique experiences of the participants can be

examined alongside the social world of practice education which is influenced by the structure of the field and the social forces at play. The participant narratives suggest the PTs/mentors and students all made decisions which could be viewed as acts of individual agency; Bourdieu, however, suggests any decisions or choices are the illusion of free will, governed by the circumstances under which the decisions are made (Jenkins, 1992). Habitus can therefore be used to frame the participant narratives, bridging concepts of social identity, individual decision making and structure, as habitus is seen to internalise social structure as the outer becomes the inner (Jenkins, 1992; Wagner & McLoughlin, 2015).

Identity and recognition

Bourdieu considers an individual's early experiences as having significant importance in the formation of habitus, underlying all successive learning and social experience (Jenkins, 1992). In a systematic review of the literature concerning professional identity Cardoso, Batista, and Graça (2014) conclude that professional identity can be framed within the context of social identity, formed through a process of self-evolution, constructed and reconstructed through interaction with others and the environment. Professional identity is part of habitus, shaped through values, beliefs and attitudes underpinning professional behaviour, where individuals interact in dialogical action (Hallam, 2000; Taylor, 1999). Bourdieu suggests players develop and acquire competence, social identity and their field position through a combination of explicit teaching and practical experience. Whilst this can result in a shared understanding of practice, Bourdieu considers that players, in order to survive and strengthen their position in the field, adopt what they experience as doxa: consciously or unconsciously they internalise the rules of the game, accepting a practical sense of logic, whereby practice is not only shaped by habitus but practice evidences the habitus that generates it (Jenkins, 1992; Maton, 2008). Abigail demonstrates how she identified with the social field of practice to such an extent she chose to stay in the placement area despite her PT being absent for some time and this affecting her learning journey.

The development of habitus in nursing can be viewed as a theory of reproduction whereby history and the established order are secured through a process of cultural reproduction which further reinforces the social structure (Bourdieu & Passeron, 1977). Gemma, Sophie and Natalie all spoke in terms of shared habitus, having been trained by the same PT or having trained the mentor they were now overseeing. This was viewed as a positive experience; however, as considered earlier in Natalie's

narrative, reproduction implies the explicit knowledge transmitted is worthy of transmission and by omission that which is not transmitted is unworthy. Newall (2005) considers it is possible to short-circuit the learning cycle as individuals do not need to learn for themselves; rather, they can learn from others' experiences alone. This point could be illustrated by Helen when she stated *"I still use that patter",* implying Helen was following a best practice template rather than engaging in cognitive thought processes. When viewed through a Bourdieusian perspective, however, reproduction can be seen as part of habitus formation as individuals were exposed to the doxa of practice, which included a process of knowledge transfer and learning with the associated development of cultural capital. Doxa is constantly challenged, including the unquestioned beliefs, assumptions, rules and norms that are taken for granted, constituting an ideology (Bourdieu, 1977; Deer, 2008; Grenfell, 2008). Bourdieu's theory of reproduction and concept of doxa prompt educationalists to be mindful of the significance of practice culture and philosophy and the structural forces at play on practice; as Jenkins (1992) concludes, habitus is history perpetuated through production and reproduction acting as social structure.

Previous research undertaken by K. Adams (2013) demonstrated that role recognition impacted upon the professional identity of PTs. This study builds upon these findings, suggesting that an evolving sense of habitus for the PT/mentor was also shaped in part by the structuring force of the HVIP. The HVIP when viewed as a social construct added another layer of complexity, including the resultant changes to the entry gate for the profession and the changes to how placements were managed. Through a Bourdieusian lens, the HVIP fundamentally changed the way practice education for HVs was managed; the HVIP is thus the context and the backdrop to the participants' experiences. The analysis therefore must be considered in terms of the relational structure of practice which includes professional identity and the significance of habitus in relation to capital and field (Maton, 2008). Unlike the mentors in the Devlin et al. (2014) and Morton (2013) studies, those in this study had volunteered for the role, and the HVIP was seen as an opportunity to train and qualify as a PT. Mentors commented on the positive elements of the educational role, suggesting they had developed capital and increased their personal knowledge with regards to educational processes and the professional practice of health visiting, a finding that is in keeping with Deave et al. (2017). This was seen to affirm their sense of habitus as they revisited health visiting processes and unpicked the intricacies of the role for the student. In keeping with the extant literature, ubiquitous concerns over workload demands were voiced by the mentors, with findings confirming previous research that

mentors struggle with one-to-one mentorship alongside clinical responsibilities, and that Trusts were perceived as not valuing or understanding the complexity of their educational role (K. Adams, 2013; Devlin et al., 2014; Morton, 2013). The findings from this study extend the literature further, adding that mentors perceived the PT role to be recognised and valued over and above the mentor role. This was seen to compound the mentors' feelings that they were not recognised for their contribution to student learning, impacting negatively on habitus. The mentors reflected upon their role and contribution to HVIP, seeing this in terms of aiding the Trust, rather than the Trust investing in them personally and professionally:

> *It's been quite difficult, stressful and you think ooh, I would like to be recognised as a practice teacher.* (Amanda)

> *That wouldn't fulfil my need though doing it on a band six. It's not career progression. I… I feel as though I'd be helping the Trust out.* (Natalie)

The relationship between the structure of the HVIP and the subsequent models of practice education therefore had a negative impact on the formation of mentor habitus. This was compounded by the probability that they would not be able to progress to a PT role due to lack of funding. The findings reinforce those in Adams' study (2013), extending previous findings to the role of the mentor, with role recognition and satisfaction being seen as key to professional identity and intention to continue in the role. Ultimately, the mentors had accumulated capital and their disposition acquired through experience had become that of a PT; however, their experience was disregarded due to the infiltration of economics into the fields of education and health (Bourdieu, 1998). The mentors' narratives can be viewed therefore as a symbolic and material struggle as they strove to achieve upward mobility (Fuchs, 2003). This is not to say the mentors' narratives are without agency, but rather are shaped by lack of recognition which can lead players to recognise the legitimacy of a symbolic order that is unfavourable to them (Hilgers, 2009), a point that is illustrated by the students hiding their identity and both mentors questioning their decision to continue in the role.

Habitus formation as part of social learning commences when students enter nursing education, continuing throughout his/her working life (Barnett & Di Napoli, 2008), and shaped by pedagogy with its unconscious borrowings and imitations (Jenkins, 1992). According to Cochran-Smith, Feiman-Nemser and McIntyre (2008), conceptions of identity share four basic assumptions: that identity is dependent upon and formed within multiple contexts which bring social, cultural, political, and historical forces to bear upon that formation; identity is formed in relationship with others and involves

emotions; identity is shifting, unstable, and multiple; and identity involves the construction and reconstruction of meaning over time. For the 2+1 students, this can be considered in relation to habitus and the collective history and beginnings of health visiting and the HVIP, widening access and new models of training. The students' habitus was formed through an intrinsic sense of identity, which was impacted upon both positively and negatively by extrinsic views during their training, and through a process of reflection and experience the students constructed and reconstructed their sense of personal and professional identity. This evolving sense of habitus was facilitated by the role the PT/mentor played and the relationship between personal and professional habitus formation (Olthuis, Leget, & Dekkers, 2007). The students perceived during their pre-registration training that they were compared unfavourably to traditional pre-registration students; habitus was challenged by negative perceptions. During their health visiting programme, their habitus was accepted and this experience shaped the accumulation of capital and formation of habitus. According to Tangney, Stuewig and Mashek, (2007), feelings of embarrassment can act as an emotional barometer providing feedback on an individual's social and moral acceptability. Such feelings were described by the students, and their narratives highlight how identity and agency are linked to the social environment and the support and respect of practitioners around them:

> *…perhaps if I hadn't been a 2+1 I might have picked up a bit more.* (Abigail)

> *I didn't tell people, if I did I'd feel they'd question me or think I wasn't as good.* (Veronica)

> *You felt embarrassed, you weren't worthy… horrible.* (Helen)

The concept of habitus can be used to understand how certain practices are regulated between social groups. The mentors/PTs shared some common beliefs, such as the use of reflection and Socratic questioning as a learning strategy. Although there were differing experiences, educational habitus can be seen to impact upon the way the placements were structured, with shared habitus being valued and co-location enabling the development of shared habitus. The mentors and PTs also described how when they themselves were trained by the same PT, this acted as familial habitus, which was described by Natalie as a "legacy". Shared habitus can be seen to have created rules and an unquestioned doxa of practice, which resulted in common action reinforcing further the players' legitimate position in the social field:

> *One of the students who was long-arm mentored… said she was happy with being long-arm mentored because we [the PT, the mentor and herself] were in the same office. So she could see that erm… we worked together and she*

> *didn't feel doubly assessed in that way… the fact that we get on well has nothing to do with it but we do get on well and we… we practise in a similar way and we've got erm… similar thoughts and feelings on some things.* (Gemma)

The PTs/mentors and students can be seen to enact a dialogical culture of practice education, learning how to act and defer within the social field; the action is dialogical as there was shared agency, yet within this culture there were also inequalities, revealed in subtle nuances of social position. The PTs were viewed as having a higher social position than the mentor, and the 2+1 students felt their habitus was questioned and compared unfavourably to traditional pre-registration students. An individual agent can only operate effectively as a constituted part of a 'we', therefore identity does not only consist of individual properties but also alignment with the field they occupy. The participant narratives suggest that the dialogical relationship was affected by extrinsic forces, at times resulting in the participants struggling to connect with the 'integral we' of practice. Students struggled with their 2+1 identity, mentors struggled with feelings of worthiness, and the PTs struggled with geographical distance between the student and themselves; all of these feelings affected the social field and the participants' sense of 'we'. When the social field changes, habitus can be challenged, causing a crisis of identity; as a result, individuals can be resistant to change as it calls into question the knowledge they have accumulated over time (Taylor, 1999).

Hysteresis

When habitus and field are in congruence, the players practise unconsciously and this synchronicity shapes the doxa of the field, characterised by alignment between position, dispositions and situations encountered by the players (Vandenberghe, 1999). Habitus and the social world can, however, become misaligned and habitus can continue to generate practice when the original conditions have gone, such as the change from one-to-one mentorship to new models of education. When this occurs, players experience a changing field and subsequent dislocation of habitus. Some players in the field will adapt as their disposition shaped by earlier experience makes them more adaptable; even though Gemma had decided not to continue as a PT, a combination of economic, cultural and social capital combined with habitus fostered a defined sense of worth: *"I know what I'm doing and I know that I'm earning my band seven… I know how much work goes in to it so I'm just confident really that I know that I'm doing a good job."* However, when the field changes rapidly such as during the HVIP and is viewed as taking a different direction to the habitus of the players, then the players can appear resistant to change, anchored to an old familiar

world. The study findings present players being propelled into a new social world. Maton (2008) refers to durable dispositions which cannot change at the same rate as the social field; this would appear to be a key finding from this study which has resonance outside SCPHN practice education as healthcare roles expand and different types of student enter the healthcare arena. Within the social field, the players occupy a position and they all experience a degree of fit or mismatch with the assumptions that prevail. The PTs, as the most experienced players, can be viewed as having the greatest fit as they had learned the state of play over many years, and this prolonged immersion resulted in practical mastery, which was recognised by the students (Maton, 2008). However, the HVIP challenged the PTs' sense of embodied capital, and when there is a misalignment between field and habitus the phenomena of hysteresis can occur. Hysteresis is a mismatch between cognitive and objective structures, described as 'a fish out of water' feeling (Bourdieu, 1977; Grenfell, 2008). Hysteresis in this study can be used to consider the changing social field and how policy changes effect change on an individual level, shaping identity and practice through habitus (Courtney, 2017).

The PTs over many years had been socialised to deliver one-to-one education: they had been educated themselves in this way, and the model constituted the objective rules of their social world and habitus. When change is slow, individuals have time to develop habitus which is aligned to the field; but when there are sudden changes, habitus and field become disjointed and hysteresis can occur, resulting in stress and isolation. Players under these circumstances can exhibit imposter syndrome (Zandy, 1995), as expressed by Helen in particular when she described her experiences as a 2+1 student in terms of "*not being a real nurse… not quite as qualified as some others*". Hilgers (2009) considers hysteresis as a nostalgia for a vanished order and habitus which were consistent with a past social field such as prior to the HVIP. Hysteresis can result in dispositions which are disinterested, incongruent and suffering, making players less able to conform with rules enforced in the field as practices digress from their sphere of legitimacy (Bourdieu, 1990). Bourdieu's concept of hysteresis can be used to consider the experiences of participants in this study, and may also have resonance with any changes that occur as part of the new NMC standards for student supervision and assessment (2018b).

The PTs expressed a defined sense of habitus when discussing the one-to-one mentorship model, referring to their role as leaders of education; however, they voiced great difficulty in accepting their new identity of long arm PT. Their narrative revealed a process of identity reconstruction as they struggled to make sense of new models

of practice education and ensuing changes to their role. The PT habitus can be viewed as a lasting disposition which guided them (Navarro, 2006). When enacting the one-to-one mentorship model, the PTs discussed their identity in terms of role clarity and a sense of knowing and being in control of the learning process. The introduction of the mentor role was seen as a threat to this constructed identity, fragmenting the educational relationship with the student and the learning process. Machin, Machin and Pearson (2011) consider that role identity fragmentation may precipitate individual role crisis, affecting optimum role performance. The findings from this study are congruent with Machin et al. (2011), as PTs described managing numerous mentors, students and the associated placement areas. This was considered to be a difficult task which had a huge impact on habitus and desire to continue as PTs. Professional identity aids professional commitment, which in turn enhances job satisfaction and reduces burnout levels (McDonald, 2004; Sabanciogullari & Dogan, 2015). However, the PTs described a loss of identity which left them feeling displaced. This is a significant professional issue as the extant literature demonstrates the correlation between workplace satisfaction and retention (Cowin, Johnson, Craven, & Marsh, 2008; Haydock et al., 2011; Sarmiento, Spence-Laschinger, & Iwasiw, 2004). A key finding from this study is that the resultant hysteresis and lack of recognition resulted in increased PT/mentor dissatisfaction. Natalie spoke in terms of being overwhelmed by her role as mentor in a busy clinical environment, voicing she would not be prepared to continue on a lower banding than the PTs: *"There's many a night I stayed late… any steps I make in the future will be career progression for me.*" Amanda also felt her role was not valued in the same way as the PTs: "*I don't think they're going to fund any more. I think it is just going to be long-arm mentoring, you just don't feel appreciated for what you're doing really."* This occurred at a time when HV numbers needed to be increased and experienced PT/mentor retention was of significant importance. Change is significant in terms of field and habitus formation and the changes imposed by the HVIP can be viewed as heteronomous, although a necessity imposed from outside (Hilgers & Mangez, 2015).

In Bourdieusian terms, the rules of the game prior to the HVIP were rationalised and understood by the PTs, constituting a logic of practice, a shared habitus (Brown & Szeman, 2000). The new role of long arm mentor would seem to have challenged this doxa, affecting the PTs' decision to continue. Both PTs suggested their long arm role made them less effective as educators, and as a result Gemma brought retirement plans forward and Sophie was considering an alternative career. Gemma felt LAM was inferior to how she practised using a one-to-one model: "*It's not as good*

as being a one-to-one practice teacher. I can't do the job as well as I could." Likewise, Sophie struggled to come to terms with the loss of the one-to-one model, suggesting that alternative models were affecting the experience and the quality of the placements provided: "*I don't want to oversee two people, I wanna oversee one. I did it while they did the implementation plan, we were sold on that. I want the quality to come back.… We used to give people six months' preceptorship and now they need two years."* The findings suggest that the changing structure of the field resulted in increased feelings of pressure, and a sense of dissonance for the PTs as they tried to reconcile their sense of habitus with the order of the new world. The PTs can be seen to have an interest in maintaining the status quo that enabled them to strengthen their domination (Hilgers & Mangez, 2015). However, although the PTs possessed capital which awarded power and authority within the field, their narratives suggest habitus and accumulated capital were threatened by the new models of mentorship. In particular, the PTs both felt the additional responsibility of managing numerous players was a fundamental change to their role, as they became less of an educator and more of a manager of people. An individual's habitus and capital will determine how well they cope with hysteresis, and the narratives suggest both PTs' accumulated capital enabled them to make decisions about their futures. Gemma had decided to retire earlier than previously planned and Sophie was considering a career move into education. It would seem that rather than endure a feeling of hysteresis, they had both decided to make major changes, recognising their habitus no longer aligned with the new social field:

> *The new model has pushed me to make that decision earlier (retirement)… it's not the way I want to be a practice teacher. It's not as good as being a one-to-one practice teacher.* (Gemma)

> *I just don't want to do this long-arm mentoring anymore… the relationship with the mentor… the relationship with the student, it's too much.* (Sophie)

The participant narratives reveal the field as an arena of struggle, and power relations can be seen to shape the experience of the mentors in particular (Thomson, 2012). Hierarchies determined the scope of the mentor role particularly with regard to assessment, and the mentors experienced hysteresis as they were unable to acquire dominant capital and were unlikely to realise their initial goal of becoming a PT. Natalie felt that as she had mentored two students she was undertaking the student's assessment: "*I felt she was confident in my assessment of my student and she was observing what I'd already told her."* Whereas Gemma considered assessment her responsibility: "*It is my responsibility… I want to work with that student… I want to see… it's fine to listen to the mentor but I need to know it myself."* The field can be

seen as a competitive place, and the participants jostled for position and the forms of capital valued in the field (Walther, 2014); this resulted in the mentors trying to reproduce the cultural practices of the dominant social group, which can be seen to legitimise and validate the one-to-one mentorship model further. Dispositions can be seen to be shaped by past events and structures, which in turn shaped current practices and structures, conditioning perceptions of these (Bourdieu, 1984). Some of the PTs/mentors felt the mismatch between habits and practice was untenable; they can be seen as suffering hysteresis, as for them the structuring of habitus did not meet the social context and logic of the field. Sadly, as Zandy (1995) suggests, this can result in players dropping out altogether.

Bourdieu considers every habitus to be impacted on by the effects of hysteresis (Bourdieu, 1977). The students described the 2+1 programme in terms of two distinct experiences, pre-registration and the health visiting programme. The first two years when the students trained to be nurses were described as particularly difficult, as they felt their identity as a 2+1 student was viewed as inferior to the traditional pre-registration student undertaking the programme over a three-year period. The students described how they felt qualified practitioners frowned upon the 2+1 programme: they were made to feel as if they had cheated the system by undertaking a shortened programme, and this in some way devalued the nursing profession and the practitioners who were already qualified. Students described practitioners' responses as defensive of the traditional route into nursing, suggesting that the 2+1 student identity was inferior. This resulted in the students feeling less accepted and as a result their habitus was incongruent with the field. Bourdieu and Passeron (1977) consider instructors to favour students who follow the dominant cultural norms, viewing these students as more intelligent; whilst Bourdieu and Passeron were considering this in terms of school children, this could also be the case for the mentors in pre-registration, who made the students feel devalued. The concept of belonging is considered paramount to the construction of nursing identity. Through acceptance and inclusion, students become confident which in turn fosters a sense of self-worth and evolving positive habitus (Walker, Dwyer, Broadbent, Moxham, Sander, & Edwards, 2014). Hysteresis had a negative impact to a varying degree on all of the 2+1 students, which affected their social enculturation into the field of nursing. Natalie drew parallels with her own training as a direct entry midwife, and for Abigail this affected her ability to see herself as a nurse: *"I think that the health visitor programme should be some kind of eighteen month, twenty four month straight in to, like the midwifery really… don't really see myself as a 'nurse' or that title of a 'nurse'."* Health

and social care systems are undergoing significant change resulting in merging of roles, changes to responsibilities and the reconfiguration of core services (Burton & Ormrod, 2011). Nurses as the largest professional group in the NHS have a huge part to play in creating appropriate supportive training and caring environments which foster positive notions of identity and an acceptance of a range of cultural capital. As previously stated, Bourdieu asserts that capital has the potential to cause inequality when certain capital is valued more than others (Bourdieu & Passeron, 1977). This is particularly pertinent for 21st century healthcare education with its expansion of routes into healthcare professions; a fundamental shift in mind-set, including its philosophy, values and attitudes, may be required to negate the negative impact on the development of secondary habitus.

Chapter conclusion

The theoretical perspective of this analysis and discussion chapter has been one of IPA and constructivism, incorporating Bourdieu's theory of practice as a conceptual framework. In keeping with constructivist research concerned with individual views of the social world, semi-structured conversational interviews elicited a rich narrative concerning the participants' experiences of their social realities. This social reality was manifest as a mental construction, and this study and its research questions set out to understand the lived experience and shared constructions of the participants in keeping with the idiographic and group approach of IPA studies. The analysis and discussion process has developed my own understanding of the meaning that the placements hold for the participants, and in so doing developed my own personal knowledge of their views of reality; this was consistent with my ontological stance, concerned with multiple realities and perspectives as opposed to one absolute truth. Relevant substantive literature has been used to orient the study and provide a dialogue for the discussion (J. A. Smith et al., 2009). Through a collaborative, interpretive process between the participants and myself, a new body of knowledge or constructs has emerged (Lincoln & Guba, 1985) concerning the experiences of practice placements amongst 2+1 student HV, PTs and mentors. However, as an IPA researcher I am aware that I am positioned as attempting to make sense of the participants' experience (J. A. Smith et al., 2009). IPA being an inherently interpretive activity means that this study can only make claims for the participants from whom it was derived, and makes no claim to generalisation; however, the detailed analysis of the participants' accounts is sensitive to context, having considered existing literature, Bourdieu's conceptual framework and the socio-political context of the time.

Chapter 5: Conclusion and recommendations

As part of a professional doctorate, this original research makes a unique contribution to existing literature and furthers professional practice (Boud & Lee, 2009). This final chapter considers the clinical and educational implications of the findings, the new knowledge found, and the methodological implications and limitations of this study including the significance of reflexivity and researcher positionality. The findings focus on the dynamic relationship between structure and agency within the social field of health visiting practice education, under the headings of the superordinate themes. The significance of the findings in relation to service provision and future educational initiatives is presented along with recommendations for future practice and research. The chapter concludes with the next steps in my personal and professional journey.

Key findings and implications

Philosophical implications: This thesis makes a unique contribution to the body of knowledge concerning health visitor practice education as the findings address a philosophical gap in the literature. No previous studies were located exploring the experiences of the 2+1 HV student and the PT/mentors who support them through the lens of Pierre Bourdieu's theory of practice. This empirical research therefore adds to the body of knowledge on health visitor practice education, and specifically highlights the impact of the HVIP (DH, 2011a) and the dynamic relationship between habitus, culture and field.

Methodological implications: This study would appear to be the first in-depth qualitative study to explore PTs, mentors and students' experiences of HV practice education utilising IPA methodology. The findings therefore present a unique methodological viewpoint to explore the idiographic and collective experiences of those involved in HV practice education.

Theoretical implications: Empirical findings indicate that policy change affects the structure of social fields and key players within the field. This thesis therefore adds to the body of theoretical knowledge regarding the impact of the HVIP (DH, 2011a), on models of education and the experiences of PTs, mentors and students. This has implications outside health visiting in the current context of changes to nurse education and the introduction of the new NMC (2018b), standards for student supervision and assessment.

Congruence between the study aim and research questions

The original research questions and the analysis and discussion chapter are related and situated with respect to the extant literature, culminating in a number of key findings conceptualised through the lens of Bourdieu's theory of practice. For convenience, the aims and research questions are repeated below.

Aim of the research

To explore 2+1 student health visitor, practice teacher and mentor experiences of practice placements and emerging practice education experiences within the context of the Health Visitor Implementation Plan, through the lens of Bourdieu's theory of practice.

Research questions

- How do 2+1 student HVs perceive and interpret their experiences when placed with mentors and PTs?
- How do PTs and mentors perceive and interpret their experiences when facilitating learning in placements for 2+1 student HVs?
- To what extent can Bourdieu's key theoretical constructs – habitus, field and cultural capital – be used to locate and understand the participant narratives?

Questions one and two were located and framed within Bourdieu's key theoretical constructs: habitus, field and cultural capital.

The social field of practice

The HVIP raised the profile of health visiting and despite missing its target number it did reverse the decline in the number of health visitors between May 2010 and September 2015 (Bhardwa, 2015) However, during this time the field endured significant structural changes, challenging roles and positions. The findings present a multi-faceted picture of the experiences of 2+1 student HVs and PTs/mentors, extending previous studies (Adams, 2013; Carr & Gidman, 2012; Devlin et al., 2014; Harries, 2011; Haydock & Evers, 2014; Haydock et al., 2011; Morton, 2013; Naughton, 2013; Sayer, 2011; Whittaker et al., 2013). During the HVIP there was a shift away from one-to-one models of practice education and this impacted upon the social relationships of the participants. The 2+1 HV student was viewed as requiring additional support in comparison to other HV students, changing how the PT/mentors enacted their roles. Initially this was described as time consuming and directive, resulting in the PT/mentor feeling under additional pressure as they supported the 2+1 student through the programme. All four students experienced changes within

the social field, and were impacted by PT/mentor sickness/absence or a breakdown in placement affecting the students adversely. The HVIP heralded opportunities for existing stage two mentors to train as stage three SCPHN mentors; however, the mentors in this study reported feeling under pressure when enacting the dual role of educator and caseload manager, exacerbated by the additional pressures when working in inexperienced teams. Shared habitus was enhanced by co-location; this improved the mentoring relationship and assessment processes. Long arm mentorship was viewed as affecting the PT/mentor and student relationships, heightening sign-off assessment concerns for the PT. Changes to the structure of the social field resulted in PTs managing complex relationships which were problematic, and both PTs and mentors alike reported feeling overwhelmed at times, affecting their sense of health and well-being.

Cultural capital

The data suggests accumulated cultural capital gave the PTs an elevated position in the field. The PTs were viewed as the dominant players even though the structuring force of the field had changed their role. Summative sign-off was seen to reinforce the position of the PT and denoted the accumulated capital held; ultimately, the students recognised the PT as the person signing-off competency, and this gave the PT a social advantage and differentiation within the field. PTs were remunerated for their role as educators, and this gave them elevated status and dominance within the field. This hierarchy contributed to the mentors feeling devalued and this was compounded by a lack of opportunity for professional progression. The data demonstrates that long arm models did result in exposure to positive learning opportunities, and overall the health visiting placements were considered by the participants to be collaborative, embodying andragogical principles of teaching and learning which developed student capital. When the students' capital accrued outside nursing was recognised, the students felt valued and accepted as part of the social field. All of the participants placed emphasis on the significance of the relationship between the student and PT/mentor, student supernumerary status and bespoke mentorship: all were viewed as impacting upon capital formation and a sense of belonging within the social field. Crucially, when the relationship altered and there were placement changes, this affected students both emotionally and educationally. A common pattern in the data was that changing placements in the consolidation period was detrimental, affecting student learning and assessment processes at a time when some students were still acquiring capital.

Habitus

Habitus and identity formation were seen to be affected by extrinsic forces such as policy changes, fiscal constraints, changes to placements and practitioners' views of capital. All affected habitus and the structure of the field, resulting in a sense of cultural and cognitive dissonance for the PT/mentors and students. Habitus formation was at times difficult for all four students: they felt unfavourably compared to traditional pre-registration students, describing extrinsic views as defensive of the traditional route into nursing. Crucially, this resulted in students feeling less accepted, demonstrating how students' evolving sense of habitus and enculturation can be influenced by mentors and clinical practitioners. Significantly, findings suggest that the students' desire to fit into the doxa of the field resulted in habitus being questioned and sometimes hidden, which impacted upon educational needs, confidence and evolving habitus. A key finding which has resonance outside SCPHN practice education is that rapidly changing fields can result in hysteresis, and this adversely affects individuals who are unable to change at the same rate. This finding has implications for future nursing practice placements in particular, as the NMC (2018b) standards for student supervision and assessment will fundamentally change how placements are structured, and how the individuals who support placements such as assessors and supervisors are prepared and supported. Mentors suffered dissonance as they felt their contribution to the HVIP was disregarded, and as a result they questioned whether they would continue. Previous research depicted PTs as suffering identity confusion (K. Adams, 2013; Haydock et al., 2011); this study's findings suggest that long arm mentorship with the additional responsibility of managing numerous players affected the way the PT enacted their role, and added another dimension which impacted upon professional identity and habitus.

Reflexivity

In chapter three, Yardley's (2008) principles of sensitivity to context, commitment and rigour, transparency and coherence, impact and importance were used to consider the quality of the research. At the end of writing this thesis, I have also reflected on the overall programme aims for this Doctorate of Professional Studies, and how these were to facilitate critical skills in advanced research. The notion of undertaking a doctorate aimed at the enhancement of professional knowledge at individual and organisational level felt congruent with my professional journey. This was, I believe, also bound up in perceptions of identity which at the time of commencing this study was firmly located as a nurse and HV. Over the ensuing years as I have transitioned into academia, I have also felt a transition in identity as I now feel comfortable thinking

in terms of myself as a nurse academic. Having undertaken research at Master's level, I believed I had accumulated capital with regards to methodology. However, it became apparent the knowledge I had was minimal and the philosophical concepts of ontology, epistemology and conceptual frameworks took time for me to understand. The language was foreign to me and the texts difficult to grasp. My reflexive journal details the difficulties I experienced in the early days, and how I questioned my position within the social field of research: "*Why do they have to use such pretentious language, it's another world and I don't know if I belong."* Frequently I would read something and believe I understood key concepts, only to become confused again when reading another social theorist's perspective. A telling comment in my journal was: *"I feel like I am becoming completely unravelled, everything I knew I am questioning. I will never get to grips with philosophy, there are too many opposing views."* I look back on these comments and realise that this was all part of the doctoral journey. Grant (2014) suggests professional nursing doctorates can generate research which fails to challenge policy assumptions and workplace rationality, thereby perpetuating neoliberalism itself. In response to Grant's concerns, I have considered the nature of this professional doctorate; and whilst the orientation of the research has a professional focus and the knowledge generated will contribute to professional practice, the study illuminates academic integrity and worth.

I have reflected upon the decisions made throughout the research process and I believe the methodology and research methods selected were congruent with the aim of the study, whilst I acknowledge there are many routes I could have taken. IPA was an enticing approach for a novice researcher with its step by step framework, but I soon realised that to do justice to IPA the participant narratives had to be considered in great detail and reported individually before any collective analysis could be made. When undertaken correctly, IPA is a time consuming method and I have reflected upon the sample size and whether I should have interviewed the PT/mentors or the students rather than both. Overall, I do believe the combined narrative offers a glimpse into the social world of health visitor practice placements from the perspective of the educators and the students, presenting both an idiographic and collective voice. IPA studies are concerned with subjective experience and the reporting of the participant experience through my own experiential lens is therefore appropriate (J. Smith, 2004); however, as the outsider within, I knew all of the participants and this may have altered their narrative. I have reflected upon this throughout the data analysis and discussion, and I hope my position aided reflexivity and interpretive analysis because I was part of the field. Bourdieu et al. (1999) considered his

familiarity with France as aiding his reflexivity and I believe the participants spoke of what was important to them; as such I feel privileged to have borne witness to their stories and what at times was their inner turmoil.

I have also reflected upon the significance of applying a conceptual framework within a professional doctorate, one that enriched the thematic exploration of practice education whilst also providing a framework through which critical engagement could take place. As I moved through the doctoral journey, Bourdieu's theory of practice was a key structuring element from beginning to end, linking the concepts, assumptions, theory and participant narratives, informing the whole research process. I believe the framework and theory selected reflect my long lasting engagement in practice education, but importantly also set the thesis within the context of broader theoretical knowledge and understanding. In so doing, this thesis has moved beyond the neoliberalist agenda of instrumental knowledge, to consider the socio-political and ideological context of HV practice learning. Bourdieu's theory of practice (Bourdieu, 1977) is indeed complex and at times I have struggled to understand his intention. However, despite this struggle I have been made to think in different ways and I am grateful that my supervisors introduced me to what has become an enduring relationship. Throughout this research, I have considered Bourdieu's theory of practice in relation to the research itself and to myself as the researcher. Bourdieu encourages us to experiment with his theory, avoiding scientific rigidity whilst maintaining scientific rigour. I hope I have applied his tools well, deconstructed what was seen and presented the social change which was occurring in health visitor practice education.

Methodological reflections

Although it is suggested that IPA as a methodological framework is congruent with the philosophy of the research enquiry, it is important to consider the documented limitations of this approach. Giorgi (2010) questions the scientific status of IPA, suggesting that IPA as a methodology is not congruent with scientific demands due to an increased chance of reporting biased results. However, a counter argument to this perspective is that qualitative research and in particular interpretive research should not be evaluated by the application of positivist criteria. Qualitative research including IPA has been developed from a rejection of post-positivist objective truth and seeks reality derived from experience. As stated at the beginning of this thesis, my ontological stance is one of interpretivism, concerned with truth and social reality, viewed from multiple realities and perspectives as opposed to one absolute truth. The

aim of the research and the research questions are in alignment with this ontological stance, concerned with multiple truths and individual experience; as such, the research is not seeking to be generalisable, but to give voice to the participants' lived experience. IPA is not a prescriptive process like quantitative research approaches (J. A. Smith, 2010), it is an approach best judged against criteria such as transparency and trustworthiness (Eatough & Smith, 2008; J. A. Smith, 2010; J. A. Smith et al., 2009; J. A. Smith & Osborn, 2008), terms which are congruent with Yardley's (2008) principles of sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance, which are used throughout this thesis. Hefferon and Gil-Rodriguez (2011) argue poor IPA can produce insufficient data which is often descriptive rather than interpretive. Having completed this IPA study, I believe I have provided sufficient detail in the form of interpretation for the reader which will enable them to consider whether this study is true to the epistemology of IPA, and also if the findings are transferable to other areas (J. A. Smith et al., 2009). This stance is summed up by Tomkins and Eatough (2010, p.255):

> At the heart of IPA's epistemology lies the assumption that experience is accessed via interpretation. Interpretation is both what enables and what complicates the process of gaining access to, and making sense of, participants' life-worlds.

Implications and recommendations

- A key finding from the study was that policy change affects the structure of the social field and when fields change rapidly hysteresis can occur; at such times, individuals with more experience and a strong sense of habitus can suffer more pronounced hysteresis. This has implications for all nursing practice placements in the current context of changes to the NMC standards for student supervision and assessment (NMC, 2018b). The new standards when implemented are likely to herald significant changes in the way practice placements are structured and the way mentors and PTs are prepared for the new roles of assessor and supervisor. Should such structural changes result in hysteresis, this has the potential to affect PT/mentor disengagement and/or attrition. A recommendation is for Trusts and HEIs to support educators through the transition period when the new standards are released, and to be cognisant of how structural changes and changing roles could impact upon the provision of effective practice placements.
- Long arm models of education, whilst providing opportunities for existing stage two mentors to train as stage three SCPHN mentors, have resulted in mentors feeling under pressure; this is exacerbated by the additional pressures of

working in inexperienced teams. Co-location of PT and mentor does negate some of the pressure felt and enhances assessment processes. A recommendation from this study is for Trusts to locate PTs and mentors together wherever feasible as this improves the PT/mentor and student relationship and aids mentor support. This will also aid the development of capital as mentors learn to enact their role. This recommendation also has implications for other nursing programmes, as the NMC standards for student supervision and assessment (NMC, 2018b), favour two separate roles of supervisor and assessor. Co-location may also enhance such placements.

- The mentors in the study suffered dissonance as they felt their contribution to the HVIP was disregarded, and this was compounded by a lack of opportunity for professional progression and remuneration. Hierarchy in the social field, particularly around summative assessment, contributed to the mentors feeling devalued and resenting the lack of protected time. The NMC standards for student supervision and assessment (NMC, 2018b) advocate a long arm approach to mentoring, there is therefore the potential for supervisors to feel they occupy a lower position in the social field than the assessor. A recommendation based on this finding is for HEIs and Trusts to be mindful of the potential for dissonance, to offer support and opportunities for career progression where possible, and for supervisors to be afforded protected time to undertake the mentorship of students.
- LAMs add to the complexity of SCPHN practice placements. Overseeing numerous players, sometimes across differing social fields, has resulted in PTs struggling to manage multi-faceted relationships. A recommendation from this study is for HEIs and Trusts to review the numbers of students and mentors PTs oversee, reverting to one-to-one models where able. Within the new NMC standards (2018b), the role and remit of the assessor should be considered with care when implemented by local Trusts and HEIs, including how many supervisors they oversee and where they are based.
- LAMs were viewed as affecting the student/PT relationship, heightening concerns with regards to assessment processes. This has implications for the effective assessment of competence and ultimately public protection. Where LAMs are used, HEIs and Trusts should review the amount of direct contact time PTs are able to spend with students in order for them to make sound judgements regarding fitness to practise. This also has implications for the new assessor and supervisor role advocated by the NMC (NMC, 2018b).

- Relationships are key to mentorship processes, and when there are placement changes and relationships are fractured this affects students emotionally and educationally. Changing placements, particularly during consolidation, appears detrimental as it affects habitus formation and student learning, and impacts upon assessment processes. A recommendation from this study is for HEIs and Trusts to consider the significance of the student PT/mentor relationship and the continuity of the placement area, and how this is pivotal to learning. Wherever possible, students should remain in the same placement with the same PT/mentor for the duration of the programme. This will maximise learning, aid assessment processes and minimise the negative impact of stress as students continue to acquire cultural capital. As the new NMC standards (NMC, 2018a, 2018b) are implemented, placement providers and HEIs are urged to consider continuity of placements and how students will be supported by the new roles of supervisor, assessor and academic assessor.
- Students undertaking different routes into nursing are affected by extrinsic views which are defensive of traditional training routes, and this can affect evolving habitus and enculturation. Students want to be accepted and when educators and practitioners value students' prior experience regardless of where it was accumulated, this strengthens the students' perception of their field position. When this does not happen it has the potential to make students feel devalued and inferior to other students. Currently there are changes to the nursing profession, including recruitment and education, which will add complexity for educators. Supervisors and assessors will be required to support a myriad of students including students undertaking apprenticeship routes, nursing associates, part time students and traditional students undertaking a three-year programme, all with varying degrees of capital. A recommendation from this study is for HEIs and placement providers to be mindful of the need to support educators to create supportive training and caring environments, which foster positive notions of identity for all students regardless of training route. Such support should include enabling educators and practitioners to understand and accept a range of cultural capital which may differ from their own.

Recommendations for further research

- Following on from this study which was undertaken in one geographical area, further research concerning SCPHN practice education is called for to

ascertain how placements are experienced by educators and students as the new NMC standards are operationalised.

- In view of the findings from this study, research pertaining to the NMC standards for student supervision and assessment (NMC, 2018b) is called for, in particular how the roles of supervisor and assessor are enacted and how this affects teaching, learning and assessment processes for a range of students.

Study limitations

IPA studies usually involve a small number of participants, often situated in one geographical area, and this study is no exception. The sample consisted of white female participants as this was the demography of the wider group, and therefore the findings do not offer insights into other groups or genders. As an IPA study the findings make no claims to be generalisable; however, it is hoped that the details provided will enable the reader to determine if the findings resonate with their experiences and are transferable to other settings.

Dissemination

As part of a professional doctorate, it is important that the findings from this study will be used to inform programme and practice development for SCPHN and other health and social care programmes. Dissemination of the findings will enable key stakeholders to consider how practice placements are managed in order to achieve optimal quality learning experiences for students, and appropriate support and preparation for PTs/mentors and the new roles of assessor and supervisor. Findings will be shared within the faculty, and with the PTs and mentors who attend the twice yearly mentor updates at the university. Preliminary findings have already been shared at the national Community Practitioners' and Health Visitors' Association conference in October 2017, and following successful completion of this thesis the complete findings will be disseminated via publication and conference presentation. A copy of the approved thesis will also be deposited with ChesterRep, the University of Chester's institutional repository and online platform for research carried out at the university.

Thesis conclusion and my next steps

As I write the last paragraph in this thesis, I have call to reflect on how my habitus has developed. Through learning I have changed as a person: I believe I have accumulated social, cultural and economic capital, and significantly I understand this

research journey has been truly transformational and so much more than attaining the title of Doctor. There have been large doses of anxiety, guilt and exhaustion as like many working mothers I have tried to balance family, full time work, ageing parents and study. I have often looked forward to when I would submit this thesis and undertake the viva; although daunting, this represented an end point. However, I have come to understand that learning is part of my embodied habitus and I cannot imagine a life without it. I will forever see the world through Bourdieu's lens; now I look forward to exploring other views as I continue to develop my ontological, epistemological and conceptual understanding in the ever changing social field of education.

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Appendices

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Appendix 1: HEI ethics approval

AM/bh

7th July 2015

University of Chester

Faculty of Health and Social Care

Tel 01244 512600
Fax 01244 511270

Debbie Haydock
Faculty of Health & Social Care
University of Chester
Riverside Campus, Room CRV412
Castle Drive
Chester
CH1 1SL

Dear Debbie

Ethical Approval Granted

FH&SC Ethics Number:	RESC0415-614
Course of Study:	Professional Doctorate in Health & Social Care
Supervisor:	Prof. Jan Gidman
Student Number:	98800694

I am pleased to inform you that the Research Ethics Sub Committee of the Faculty of Health and Social Care approved your project ***"2+1 Student Health Visitor, Practice Teacher and Mentor experiences of practice placements: a multi perspectival hermeneutic phenomenological enquiry within the UK"*** on 25th June 2015.

Approval is subject to the above and following conditions:

1. That you provide a brief report for the sub-committee on the completion of your project.
2. That you inform the sub-committee of any substantive changes to the project.

We approve your application to go forward to the next stage of the approval process. If you are applying to IRAS and require a sponsorship letter and insurance documentation please contact Barbara Holliday.

If you have any questions or require any further assistance please contact Barbara Holliday on 01244 511117 or by email b.holliday@chester.ac.uk

Yours sincerely

[redacted]

Chair, Faculty Research Ethics Sub-Committee

cc Research Knowledge Transfer Office
cc Academic Supervisor

Appendix 2: Trust ethics approval

for you, with you

Wirral Community NHS
NHS Trust

Quality and Governance Service
St Catherine's Health Centre
Derby Road
Birkenhead
CH42 0LQ

Tel: 0151 514 2888

www.wirralct.nhs.uk

Date: 4th April 2016

PRIVATE & CONFIDENTIAL
Debbie Haydock
Faculty of Health and Social Care
University of Chester
Riverside Campus, Room CRV412
Castle Drive
Chester
CH1 1SL

Dear Debbie,

RE: Full title of research project:

2+1 Student Health Visitor, Practice Teacher and Mentor experiences of practice placements: a multi perspectival hermeneutic phenomenological enquiry within the UK.

Thank you for applying for Research and Development approval to conduct the above research study with staff employed as Health Visitor Practice Teachers or Mentors by Wirral Community NHS Trust as part of your Professional Doctorate in Health and Social Care.

I am aware that this research project will involve interviewing four members of staff during their working hours for a period of approximately 60 minutes, thus removing them from clinical practice to be interviewed during this period. I can confirm that we will support staff involvement in your work, as the benefits of engaging with practice teachers and mentors to seek their views and experiences of the new models of Health Visitor practice education in the UK, will add a wealth of knowledge to clinical practice and nurse education. I hope that this knowledge will be used to benefit both patient care and staff in the future.

I hope your study progresses well, and would be most grateful if you could provide a summary of your findings on completion of your work.

Yours sincerely

[redacted]

Medical Director

cc: Claire Wedge, Head of Governance and Patient Safety

Positive About Disabled People
MINDFUL EMPLOYER
Rated as good by: CareQuality Commission 18 November 2014

Appendix 3: Participant information sheet

Practice Teacher/Mentor Participant information sheet

2+1 Student Health Visitor, Practice Teacher and Mentor experiences of practice placements: A multi-perspectival hermeneutic phenomenological enquiry within the UK

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

What is the purpose of the study?

Changes in recruitment criteria have afforded exciting opportunities for nurses to enter the field of health visiting via an accelerated route. Several universities offer '2+1' programmes, where a graduate with a health related degree can obtain APL (accreditation of prior learning) and complete their pre-registration nurse training in two rather than three years, leading to first level registration. This is then followed by a one-year post-registration Specialist Community Public Health Nurse- Health Visitor (SCPHN-HV) programme. This widening of recruitment has afforded a unique opportunity to study 2+1 student perceptions of their placement experience and those of the Mentors and Practice Teachers (PTs) who facilitate new models of SCPHN mentorship as outlined by the Nursing and Midwifery Council (DH, 2011).

The aim of this study is to explore the educational practice placement experiences of 2+1 students undertaking the health visitor programme and the experiences of the Mentors and Practice Teachers whose role it is to support and assess these students. This study is undertaken as part of a doctoral programme of study and will be written up in thesis format. The findings from the study will be used to inform the future development of educational placements for health visitor students and their Mentors and Practice Teachers.

Why have I been chosen?

You have been chosen because you are a Practice Teacher or Mentor facilitating a 2+1 student on the health visitor programme.

Do I have to take part?

It is up to you to decide whether or not to take part. If you decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time and without giving a reason. However, should withdrawal occur after the data collection has taken place, the researcher will retain the data collected in their research records. All identifiable

tape recorded interviews will be destroyed however the researcher will need to use the data collected up to your withdrawal.

A decision to withdraw at any time, or a decision not to take part, will not affect your educational programme of study in any way.

What will happen to me if I take part?

If you decide to take part, you will be given this information sheet to keep and asked to sign the consent form. This will give your consent for the researcher from the Faculty of Health & Social care at the University of Chester to contact you to invite you to participate in a one to one interview. During this interview, you will have the opportunity to raise and discuss your views and experiences relating to your practice placement educational experience. The interview will last about an hour. With your permission, interview will be audio taped. No participants in the study will be identifiable in the final report.

What are the possible disadvantages and risks of taking part?

There are no disadvantages or risks foreseen in taking part in the study.

What are the possible benefits of taking part?

As a Practice Teacher or Mentor you may welcome the opportunity to share and discuss your views and experiences of facilitating a 2+ 1 student educational practice placement. By taking part, you will be contributing to the development of health visitor practice education through sharing your views, which will hopefully benefit both students, Practice Teachers and Mentors in the future.

What if something goes wrong?

Should you disclose concerns about professional practice these will be escalated through Trust procedures and University of Chester procedures.

If you wish to complain or have any concerns about any aspect of the way you have been approached or treated during the course of this study, please contact:

Professor Annette McIntosh-Scott,
Executive Dean, Faculty of Health and Social Care
University of Chester
Riverside Campus
Castle Drive
Chester, CH1 1SL.
Tel: 01244 513380. Email: a.mcintosh@chester.ac.uk

If you are harmed by taking part in this research project, there are no special compensation arrangements. If you are harmed due to someone's negligence (but not otherwise), then you may have grounds for legal action, but you may have to pay for this.

Will my taking part in the study be kept confidential?

All information which is collected about you during the course of the research will be kept strictly confidential Information will be restricted to those involved in the study: the researcher and her supervisor's. The lead researcher will be responsible for

ensuring that stored material that contains identifiable information, is kept securely and that data is coded so that it is anonymised.

What will happen to the results of the research study?

The study results will be written up as a doctoral thesis and as such are part of a doctoral programme of study. It is hoped that the findings may be used to improve the educational placements of health visitor students and the preparation and support required by Mentors and Practice Teachers. Participants in the study will not be identified in any subsequent report or publication.

Who is organising and funding the research?

The research is will be conducted as part of a doctoral programme of study. The Faculty of Health & Social Care at the University of Chester will be involved in overseeing the study. The researcher as a doctoral student will participate in regular supervision with experienced researchers to ensure the study is robust and reported accurately and fairly.

Who may I contact for further information?

If you would like more information about the research before you decide whether or not you would be willing to take part, please contact:

Deborah Haydock M.Ed, BSc (Hons), QN, RGN, RM, SCPHN-HV, CPNP, RNT, FHEA, FiHV
Programme leader for Practice Teacher programme/Deputy programme Leader for SCPHN
Department of Community Health and Wellbeing
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Appendix 4: Consent form

2+1 Student Health Visitor, Practice Teacher and Mentor experiences of practice placements: A multi-perspectival hermeneutic phenomenological enquiry within the UK.

Name of Researcher:

Deborah Haydock

Please initial box

I have read and understood the participant information sheet and have had the chance to ask questions.	☐
I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.	☐
I understand that with my permission the interview will be audio-recorded.	☐
I understand that the data will be written up as part of a report and that I will not be able to be identified in the report.	☐
I understand that should I disclose concerns about professional practice these will be escalated through Trust procedures and University of Chester procedures.	☐
I agree to take part in the above study	☐

Name of Participant	Date	Signature
Name of Person taking consent (if different from researcher)	Date	Signature
Researcher	Date	Signature

Appendix 5: Literature search strategy

Search term	Data base	Exclusion criteria	Number of articles	Relevance to subject area
2+1 nursing programme	Library classic search	None	12	5 grey articles
Student health visitors practice placements		None	1200	5 research papers 1 discussion paper
SCPHN PT		None	196	3 NMC documents 5 DH documents 11 grey articles 4 research papers
Health visitor practice teachers		None	1986	1 discussion paper 2 grey articles 3 research papers, 2 appear above
Health visitor mentors		2009 onwards to coincide with the HVIP	1714	2 research papers included in both searches above 3 grey articles 3 discussion
SCPHN practice education and practice placements		None	1959	2 research articles included in searches above 1 discussion paper
SCPHN mentor		2009 onwards to coincide with the HVIP	1440	2 research articles included in searches above

Appendix 6: 2000 word extract from one interview 711_0272 (48:48)

Participant: It is quite difficult and it can be quite stressful and you don't realise when you see somebody else doing it and people think oh they're a mentor or, you know, they don't realise the level of responsibility and it is, it is stressful because you feel the pressure that you've got to get this erm…student to a very high level and as you say, within a short period of time. So there's a lot of pressure on you. Or you get pressures from the team because they're looking to have somebody…oh yes let's…we…we want a new, you know, a team member who can actually do carry out some visits.

Interviewer: Yes.

Participant: So it's about pressures from different areas but you are conscious that you want to give them a very good experience and give them a varied experience, so it's, you know, constant planning and organising your diary and it does get frustrating when, you know, families and things that you've booked in, you know…

Interviewer: They cancel.

Participant: …they cancel.

Interviewer: Yeah, yeah.

Participant: They're not in and…and sometimes it just always seems to be like that. You've arranged them to come out or a week and things just turn around and you think gosh this hasn't worked out how I planned it to be.

Interviewer: Yeah, yeah.

Participant: So it can be stressful at times but I'm…I've…I've enjoyed it. I mean…and I think erm…and you…it is a bit like a rollercoaster for them as it is for you. Sometimes you think right, ooh, you know, I thought ooh, she might be up to this point at this point and actually we're not where we should be. Right what do we do, what do we need to do now, let's think what we need to do. Cause I do find it's about confidence and it's that actually doing visits by yourself, even if it's part of visits within, you know, the experience…the visits sorry that they share and do part of the contact.

Interviewer: Yeah, yeah.

Participant: That initial…it's quite difficult and then when again, they're coming to do the whole visit themselves, they're worrying about it so it's again, how do we look at that, how can we make it easier and often it is, you think right, at this point let's go back to basics again and let's share, cause sometimes they can't, you know, when…when you've been doing it for a while you've got that experience, you know the questions to ask, you know how to go if they go in one direction you can come back round, you can go with their agenda and come back to it and sometimes they can get foxed by things like that. So it's sharing with them how could you possibly remember all these questions, the paperwork, cause you don't want to go out with tons of paperwork.

Interviewer: Of course.

Participant: And you do find them thinking, well initially you don't mind if they take the paperwork out. They start asking the questions and getting a rapport going, you know?

Interviewer: Yeah, yeah.

Participant: You want to start…cause I think sometimes we don't get them to do enough initially and that's a barrier then because it becomes a big thing that when they have to undertake their own visits. So I do think we need to get them goin…you know, in to the role quickly with the small things that they can do. Clinic's a good one, initially just talking to families as they come in, plotting the baby's weight, doing part of the reviews, cause I think that helps cause if you get them talking you know, it's not such a big hurdle to climb is it? But I think I found that in some of the students I've had is to go back to basics cause when they're talking…thinking about how they do a whole visit like a birth visit is how do you think about doing that, you know, without taking all your questions and I've sat down with them and said right well this is how I would do it, it's not necessarily how you would do it but I always think about PIES, the physical, intellectual, emotional, social and…and say right, this is how you do it for the mum, this is how you do it for the child and try to build up a picture so they can think, you know, cause sometimes you stop mid-flow and you think how…how can you get back…back in to the flow of the conversation…

Interviewer: Yeah, yeah.

Participant: …and direct the questions.

Interviewer: So it's interesting what you said. I just want to pick up on something there. You talked about obviously they need to understand about public health, they need to understand about the visits, but you're also saying it's also about confidence. So it's almost two elements to it isn't there? You're trying to do as a practice teacher is around building confidence as much as building competence stuff if you like?

Participant: Yeah. I think confidence is key.

Interviewer: Mm.

Participant: It really is because if you feel you can do the job, you know, you do…and you notice the students who have…have the ability to do it but don't feel they have the confidence to actually go and do the visit and you really encourage them and you're thinking right, I need to step back here and you step back and you let them do the visit and you're there and afterwards you're going how…how…how was that for you? Well, you know, and you think I didn't actually need to be there did I cause you could do the whole of the visit yourself and you did it all yourself but it was just you needed that…that cushion of me being actually there in the visit but you know, sometimes you think it's an opportunity missed really when you think right, next time go and do it yourself, cause it is that confidence.

Interviewer: Yeah.

Participant: That they actually can do it but getting them physically to do it, it's a bit of a hurdle.

Interviewer: And it'll vary from student to student won't it, when they're ready, and you've got…you're thinking about that.

Participant: And that's the other thing is that they are ready at different times and I do think going back to the first student I had and who didn't manage and I think at that time she was probably the first, one of the first ones who was a two plus student, two plus one student and I think we were looking at it from somebody who'd had experience, who might

have been a staff nurse and gone through the programme where as it's different and I think if she'd had maybe…I think it's a shame, I think our expectations were too high.

Interviewer: Right.

Participant: And I think…it was a shame, I mean, she chose that she…you know the course wasn't for her.

Interviewer: (At same time) It wasn't for her. Mm.

Participant: But I think at that time our expectations were too high and I think possibly she would have needed…she would have needed an action plan but I think it's ourselves as well, was having the confidence to think well actually we need to extend the time in which she observes a bit longer and before she's doing visits herself and we can extend that and do that without, you know, and getting her to pass her course.

Interviewer: Yeah, absolutely.

Participant: But I think at that time it was new.

Participant: And we have the confidence of doing that and the peop…students are individuals aren't they?

Interviewer: Yeah, absolutely.

Participant: And people learn at different levels and I do think she would have needed an action plan but if we could have extended it and thought about it and put in but I think things happened.

Interviewer: Yeah.

Participant: And that's a shame.

Interviewer: And as you say she chose anyway, it wasn't for her so.

Participant: Yeah, she chose.

Interviewer: So you've…you've talked a little bit about this as well. So what are the positives and negatives about being a mentor for you?

Participant: It is good for my practice to keep up on research and evidence based practice because you do keep on top. You read all the journals and you're looking for things…for articles for them to be interested in. You think oh yes, look, I'll get that for the student and that's interesting, that's sort of current, that's up to date. Definitely make sure that you're up…you've upped your game and that you're on top of everything and you keep on top of and new things and that you're more…I would do all the training because I'd want to know…find out if I was having to do…there was a new implementation or anything, I'd want to know how to do it myself because I've got to share this now. I want to know how to share it properly (laughs) you know?

Interviewer: Yeah, yeah.

Participant: So you want to get involved with everything. So we do new…two in…two year integrated reviews, well I'll do the training, I'll go and I'll organise that myself because I've got to share with my student. So you do…it does keep you on top of your game, so that's good, and it keeps you enthusiastic about work as well because you're bouncing

ideas off each other and you see it from a different…like cause somebody comes with you on your visits and then when you reflect in the car or back at the base you can see things differently. I might not have seen something that she's seen and I'll think oh yeah, well that's interesting isn't it?

Interviewer: Yeah.

Participant: I've learnt that from you, you know, and I can take that on board and improve my practice. Or they might have said ooh, well why did you do it that way, couldn't you have done it, you know, in a different way. So it is good cause it does keep you on our toes and…

Interviewer: Fabulous.

Participant: Yeah.

Interviewer: So any…any negatives or?

Participant: Negatives?

Interviewer: I mean it's lovely that mentioned all the positives, but have you…there might not be any??

Participant: I think…no…I…I think sometimes it can be…it's…you know on top of your caseload sometimes you do get behind. I noticed November/December time when it's that stressful period.

Interviewer: Yeah.

Participant: And there you're trying to think about what they're doing and you're constantly talking about the visits and what you're doing that you don't get on top of your work on those two days that they come out and you find that you do work at home.

Interviewer: Yeah.

Participant: But that's par for the cour…and some people don't fully understand that you still get a full caseload, you know, you have got a student.

Interviewer: Yeah, yeah.

Participant: So sometimes protecting the time, I would protect the time, but that might not reflect on what my caseload is. I would make sure we've got some time.

Interviewer: So what's the impact…cause obviously you know, you're protecting the time for the student but then that has…you're saying that has an impact on you.

Participant: So that then I'd work at home to make sure I'd get my visits on…on the computer and make myself feel better about work cause I wouldn't want a backlog of work. I've just got to start the week afresh. So…so I'd work at home and…yeah. So sometimes you do…it is, you know, it's balancing.

Interviewer: Yeah.

Participant: A balancing act and you have to make sure and I think it is difficult because in terms of the work…I mean we've gone through a lot of changes in terms of how we're delivering and we've gone to four big teams which happened in November/December

when we did have a little bit of a wobble. I think it was just a lot of changes happening, lots of people hot desking…

Appendix 7: Sample interview schedule for practice teacher/mentor

1. Please can you tell me about how you came to be a mentor/PT?

2. Can you tell me a little about the preparation you have had for the role?

3. Can you tell me what the role of PT/mentor involves for you?

4. Can you tell me about your experiences of the HVIP and new models of SCPHN practice education?

    Prompt

    How does it feel to be long arm mentored by a PT or how does it feel to long arm a Mentor?

    What are your experiences of long arm mentorship in relation to the 2+1 student?

    What do you think the student thinks about this placement education experience?

    Who in your opinion is assessing the students' competence?

5. How do you think others perceive the role of the PT/mentor?

Appendix 8: IPA framework step 3 applied to one excerpt from a transcript

Emergent themes searched for and data volume reduced. Patterns, connections and interrelationships mapped and shift made from transcript to notes. Gradual withdrawal from participant narrative to researcher's interpretation. Participant narrative in green

When asked about how she feels about the PT assessing the student she wants to be in control as she feels she is assessing, PT verifies. She is doing the portfolio, and action plans and has ownership she seeks control, remember she is an experienced autonomous practitioner, there is a sense of loss of control*., I do feel that I am assessing the student and I'm doing all the paperwork and I'm assessing on a day…I'd say that (Name) is verifying* she uses language such as verifying her competence: power struggle. verifying – to prove the truth of. As capital is built she becomes confident, now with her second student she seeks more control. Describing here a collaborative arrangement but as she has become more confident she wants full control. When she is signed off as a stage 3 then what?? Will she be cast aside and the cultural capital attained deemed worthless

She still feels one assessor is better *me I'd prefer to have just one person to go to,* she thinks the student feels the PT is the assessor *they probably think the practice teacher is assessing* Although she previously said she was the assessor now she refers to a higher level assessment that the PT does and refers to the significance of sign off *I suppose that she has the sign off you see, that's the difference isn't it? She's signing the practice off, I'm not actually signing-off.* She can be seen to prepare the student for the PT, does she recognise the position within the field the symbolic power of sign off *I do prep a little bit before they go to make sure they feel confident enough to do the visits cause you do think it's an extra…a higher level assessment (laughs).*

Describes the physical environment but also the person centred aspects. Feeling part of the team, settling in and learning the basics first so that they become more confident. Positives talked about with regards to mentoring *good for my practice to keep up on research and evidence based practice I want to know how to share it properly you've upped your game* Feels she knows more and has read more because she is a mentor*, it does keep you on our toes.* She describes developing her cultural capital: Upped her game, she recognised that the role required more than the HV role on its own. Recognises she is learning from student as well, students add to the habitus and the field.

Discussing the challenges of one to one struggling to establish a relationship that is close enough to teach but describes being one step away in case there were issues. The PTs see this differently and miss the one to one and the close proximity of teaching and assessing. Describes being a mentor as difficult, pressure to get the student to specialised level; pressure from teams to get the student to take cases. Balancing these demands against the need to ensure she gives the student a good experience. Managing the learning environment, dynamic nature of community-no access visits all impacting on education. Her narrative suggests others do not recognise and value the cultural capital of the mentor or understand her position in the field and the difficulties involved.